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A Christmas Reverie

Glory to God and Peace on earth to men of good will

REACHING far back into my childhood memories, my first recollection of Christmas is fixed in my mind by an unusual bit of decoration that intrigued me then and for a long time afterward. Strung from one corner to another of the room where the children had placed their shoes in readiness to receive the gifts of the Christ Child, was a cord to which the flags of many countries had been attached. I can still see the dragon of the Chinese Empire, the Rising Sun of Japan, the star-spangled emblem of the U.S.A. — a fascinating spectacle for my childish eyes. I could never understand how this display had found its way into the midst of the red and green garlands and sparkling stars.

Years later, after the war, this memory came to mind again and I found that this particular decoration was completely appropriate to the Christmas season after all. Was not the angels' message directed to *all* men of goodwill, anywhere on earth?

Let us try to understand what is meant by "men of goodwill" and the peace promised to them.

Without resorting to philosophical analysis or weighty research, my definition of the "man of goodwill" is anyone who truly wants to do good and who gives of his best in anything that he attempts. The measure of his goodwill is not in the result obtained but rather in his desire to do what is right

(Marin Portraits)

SUZANNE GIROUX

and the effort he puts forth to attain this objective.

Viewed thus, how great do even the simplest acts appear and how futile the strife between persons and classes! Quite another sense of values is revealed, if we take into consideration the goodwill brought to bear upon one another in daily living.

Each culture and each country has its varied customs that, in comparison with our methods, may seem shocking or backward. But if we study the history, and development of that area more closely, we find there, as in our own environment, men of goodwill whose deeds are great because of their desire for that which is good. How wonderful life would be if each one of us with all the goodwill at our command would seek to recognize the same quality in the actions of our fellowmen.

Nurses more than anyone else, it seems to me, are "men of goodwill." Consciously or unconsciously they want to do good. Otherwise, how can you explain their calling, their acceptance of weary vigils, their desire to relieve suffering and to help their fellow-creatures? How good it would be to earn one's living in an environment where everyone displayed this eagerness to do good and put the best of themselves into their actions. The advice that Toby gave to his son concerning almsgiving applies here: "If you have little, give little; if you have much, give much but, in all cases, do it willingly."

Each individual has his special talents. We cannot all be scholars or distinguished leaders, but we can *all* possess the spirit of goodwill and, through a simple life filled with kindly acts, contribute as much to the peace of the world as the greatest leaders on earth.

One had to experience the war years to gain a true appreciation of the nobility of our profession. When all else seemed to contribute only to destruction, the nurse exemplified the brotherhood of man — a quality characteristic of few professions. At all times she can be "a symbol of brotherly love and joy."

To those who practise the spirit of goodwill in all their activities, peace is the reward. Pascal defined peace as the "sovereign good" or the *summum bonum*. What more can we ask? Perfect happiness is not the lot of anyone in this world. Wealth belongs to the few but everyone can possess peace. Peace brings a sense of serenity, contentment and confidence into our lives. If we have given of our best at all times, have looked upon our fellowmen as our brothers, how can we not have peace?

Tranquillity or spirit and of conscience gives us peace. It can belong to each one of us whatever our environment or state of life. This peace is almost perfect happiness on earth.

These reflections may seem a bit out of keeping with the general spirit of rejoicing that Christmas brings, but they really are not. They have been put into words for the express purpose of wishing Canadian nurses everywhere that Peace promised by the angels.

SUZANNE GIROUX
Visitor, French Schools of Nursing, A.N.P.Q.

Save Yourself Three Cents!

It has been learned from the post office authorities that our subscribers may send the printed "change of address" forms that are supplied by the *Journal* as third class mail. The postage is only two cents providing the flap of the envelope is turned in, *not sealed.*

Please be sure to complete all of the information on the change of address form before you mail it: Registration number and province, name, the old and new addresses, and the date when the change becomes effective.

Please allow as long as possible — six weeks is best — so that the name plates may be changed correctly.

The Problem of Poisons

JOHN DEAN, M.B., M.R.C.P.

NORTH American children are astoundingly healthy these days. Prosperity and preventive medicine have so far reduced the damage done by infectious diseases that the statisticians now tell us that accidents are the biggest threat to physical health faced by anyone from 1 to 40.

Motor vehicles, falls, burns and drowning of course produce the worst risks but any list of hazards has poisons somewhere quite high up. About 500 children die annually in North America from poisoning and for each death there are probably between 200 and 500 children less severely affected. It is to study, and if possible prevent, this enormous wastage of life that over the last five years a system of poison control centres has been set up. There are now at least 30 in Canada and over 200 in the U.S.A.

These centres are usually found in the larger hospitals and provide a 24-hour service of advice to doctors and parents faced with a child, or sometimes an adult, who has consumed one of the multitude of mysterious substances we have in our homes today. Affluence has brought many other things besides health. It has produced an array of cleaning agents, drugs, fuels, cosmetics, inks, glues, paints, pesticides, plants and many other such things which would have quite astonished our grandfathers. They make life much fuller and easier. Mostly we have not the slightest idea of their composition and still less of their effects.

No doctor, however learned, can possibly remember the make-up of the 10,000 or so products that are likely to be in our homes, nor can he keep up with the flood of new products — at least 80 new drugs are marketed every month. It is the job of the poison control centres to keep a reference library of as many of these things as they can, to have someone who knows how to use it intelligently, to know where to look for further advice when necessary, and to have good facilities for treatment. This often means that they are set up in the emergency departments of hospitals and are staffed by the nurses of these departments. In Canada the Federal Department of Health and Welfare has compiled a great list of household products and proprietary drugs and, together with some of the excellent textbooks published in the last few years, this provides the backbone of most such libraries. The hospital pharmacist is usually well in the picture and attached to each centre are a few doctors who take a special interest in poisonings. In the bigger cities there is often help to be got from the city analyst, the university departments of pharmacology, botany and zoology, wholesale chemists and quite a variety of other people. As a final resort, sometimes a long distance call has to be made to the manufacturers who these days are only too willing to be helpful.

As well as providing advice and treatment, most centres are associated with the local public health departments and report their cases to them so that visits can be made by public health nurses to the scene of the accident. This may sound a little like locking the stable door, but in fact it provides an excellent opportunity for teaching the family, and sometimes the neighbors as well, a good deal about home safety in general.

From the records of the centres and of the follow-up visits we are beginning to learn a good deal about the how and why of poisonings. They happen mostly to children between one and four — though sometimes the older child poisons the baby while playing doctor. They happen most often between 10:00 A.M. and 5:00 P.M., during mother's telephone sessions or while she is hanging out the washing. They happen anywhere around the house — kitchen, bathroom, bedroom, living room, basement, garage, garden or garbage can. They happen in other people's houses too because a visit is

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often a time when precautions are relaxed. They happen because people leave acetylsalicylic acid tablets on bedside tables, digitalis in their purses, bleach in milk bottles, lye in cups, turpentine in whiskey bottles and catch drips of fuel oil in soup plates. They happen because people hate to throw away unused medicines and because children can climb to incredibly high places. They happen because people store poisons with foods and medicines and because labels fall off or become unreadable. They happen because medicines come nicely flavored or candy coated. They happen because people use cleaning fluids in poorly ventilated rooms. They happen because people try to poison mice or slugs and poison their children instead. And they mostly happen simply because people just do not realize the risks — acetylsalicylic acid is such a useful drug, used and recommended so often that no idea of danger is ever associated with it.

The list of things swallowed is of course endless. "You name it and some child has eaten it" was one way of defining the problem. But experience soon shows that a small number of things cause quite a lot of the cases and thereby offer hope of control measures. Out of 850 phone calls to the Vancouver centre in 1958, cleaning agents such as bleaches, detergents and polishes made up 168, acetylsalicylic acid in its various forms 64 and kerosene, turpentine, lighter fluid and related compounds another 64. Of 500 cases treated in B.C. hospitals in a recent six-month period, ASA accounted for 125 and the oils for 67. Acetylsalicylic acid is by far the commonest cause of fatal accidental poisoning, though in some parts of the U.S.A. kerosene comes first.

So far not too much has been added to the treatment of poisonings though some of us are becoming more adept at the symptomatic treatment which is so often all that we can offer. The antidote is mostly a fiction writer's dream, though a very few specific ones now exist — for morphine products, for heavy metals and perhaps one or two others. From well-equipped centres we hear more of the use of exchange transfusion or the artificial kidney. All this, however spectacular, comes second best to rapid first-aid measures to eliminate the poison. Vomiting can be induced under almost all circumstances and is certainly quicker and probably more efficient than the horrid gastric lavage. Most people possess a forefinger or a toothbrush handle! In acid or alkali ingestion vomiting is though possibly dangerous and dilution with lots and lots of water is preferred. We are still not certain about kerosene poisoning. But whatever is done *speed is essential.* Children's stomachs empty very quickly and gastric lavage after about an hour often fails to return any of the poison. Don't hope for the best — do something ! ! !

Prevention is the ideal treatment of any disease. Educational effort on the widest scale is needed to warn parents of the dangers in every home. Press, radio, T.V., doctors in private practice, public health departments, Parent Teacher or Home and School Associations and other agencies can all play their part. Parents must teach their children by precept and example that food is the only permissible thing to put into the mouth. Labelling of poisons is a very obvious step but the difficulties of definition, legislation and enforcement are prodigious. So many poisons are admirable substances in their proper places that restrictions on their sale might produce undue hardships to seller and consumer. Progressive manufacturers are certainly alive to the problem and some makers of ASA tablets and insecticides include warnings on their labels. Ensuring that they are read is quite another thing though it is quite certain that a large skull-and-crossbones on a label is unlikely to promote sales! Containers offer another field for improvement. The use of safety caps which would resist the efforts of most three-year-olds would markedly cut down the number of drug poisonings and some makers of ASA tablets are now doing this. The substitution of less toxic products for the ones popular at present offers another possibility — carbon tetrachloride is an obvious target — but sometimes cost and lessened efficiency are deterrents to action.

Many of the factors which produce poisonings underlie other home accidents. Total unwareness of the dangers of so many household appliances

combined with the unguarded moment to produce burns, drownings, falls, lacerations and electrocutions. Nothing can or ever will replace constant vigilance on the part of parents, but it is the clear duty of everyone of us to let them know what they have to be vigilant about. Well child care is now incomplete without the teaching of accident prevention.

Boracic Acid — The Wolf in Sheep's Clothing

CLAIRE HALLIDAY

THE Brown's nine-month-old daughter had diaper rash for which zinc oxide had been prescribed. Not content with the child's progress, the father added a liberal amount of boric acid to the jar. The mixture was used for six days when the blue, almost unconscious baby was brought to hospital. In three hours her temperature was 105° and she died shortly after.

In the last few years, more and more doctors have taken a serious view of this so-called mild antiseptic. They have collected from medical literature reports of babies and adults poisoned by boron products — boric or boracic acid powder, borax, etc. In their survey 109 cases were listed; of these, 60 died. Of the babies under one year, 70 per cent died. One infant died after being breast fed; the mother's breasts were regularly cleansed with boric acid solution.

Because of their poisonous nature and questionable benefits, boron compounds were banned in Montreal and Toronto hospitals three or four years ago and in many other hospitals since. Their popularity seems to have survived only in the home, although some doctors still look upon them as relatively harmless.

Boron is a non-metallic element. Borax, boric acid, boracic acid, sodium perborate, sodium pyroborate — are all forms of boron. It is used for softening water and for making solutions, mouth washes, eye lotions, dusting powders, baby powders, douche powders, ointments, borax and honey preparations, etc. All of these forms have been involved in poisonings that ended in death. (Some firms make a point of advertising that their product contains no boric acid.)

A two-week-old baby had thrush that the mother treated with borax and honey as her mother had done. The baby liked it, and even after the sores had healed the mother continued to smear the mixture in the baby's mouth. It might prevent another attack. Two months later the baby died of boracic acid poisoning.

At one time borax and boric acid were put into dairy products to preserve them. This is now illegal. In hospitals it was used in the distant past for practically every condition — infected wounds, burns, eczema, and by mouth for peritonitis, diarrhea, kidney conditions, etc. A man died from having boric powder packed into a wound after an operation. It has not been used in hospitals in this way for many years.

Even though in hospitals boron preparations were no longer used internally, they were still kept in hospital nurseries for use as a mild antiseptic until many cases of fatal poisoning proved that the substance was not even safe to have around. One doctor wrote, "When a drug can be shown to be almost entirely ineffective, and at the same time dangerous, even when used in ordinary ways, it is time to remove it from general use as rapidly as possible." Fatalities rose when boric acid was mistaken for something else. At one hospital, six of eight infants died because a solution of boric acid was used to prepare their formulas. In another hospital, 20 babies were poi-

Miss Halliday works in Montreal.

soned when boric acid powder was put into their formula instead of dextrose; five died. In yet another, babies were given boric acid solution instead of drinking water; six died.

These tragic cases are always reported in the news, but the habit of keeping a can of boracic acid in the bathroom dies hard. So across Canada this dangerous substance is being made into solutions to bathe infected eyes, wash mother's nipples, swab baby's sore mouth, gargle father's throat. But the most common, and the most dangerous use, is in treating diaper rash. Instead of asking the doctor, some mothers apply boracic acid powder every time the diaper is changed. One woman used the lotion on the diapered area for a week, and when there was no improvement she bathed the baby in boric acid solution and dusted the skin for two more weeks before the baby died.

Tested by various groups of specialists, boric acid powder has been found to have "no practical antiseptic effect whatever." The Montreal specialists in children's diseases, Dr. Richard and Dr. Alton Goldbloom state that boric acid powder is one of the weakest antiseptics and any good qualities it may have are outweighed by its poisonous ones. It should be emphasized that whether a boron product enters the body by swallowing, or through the mucous membranes of mouth, eyes, or through wounds or chafed buttocks, once in the body it acts as a poison.

Poisoned babies show a red rash on the body; later the skin peels. There is vomiting and diarrhea; the lungs, adrenal glands, liver, kidneys, and brain are damaged. Some babies become blind and deaf before death; others develop pneumonia. The central nervous system is affected as in meningitis. Convulsions frequently develop, followed by delirium and coma. Doctors believe that many mild cases of boric acid poisoning have gone unrecognized because the symptoms are less severe.

Summing up his experience with boric acid after reading reports of casualties, one specialist said, "In my practice I see no indication for the use of boric acid in any form whatsoever. The above report bears out once again the toxic dangers of this substance."

But old remedies gain a certain prestige and nurses will find boracic acid in many Canadian medicine cabinets. Who knows how many babies will still be poisoned by it?

Silicone ointments have been found to give better results in preventing pressure sores than the washing, rubbing alcohol and powder treatment. From previous work it was clear that a silicone preparation with 10% or less silicone was not effective in the prevention of pressure sores. Recently a series of trials was carried out in England to determine what strength of silicone was most effective. Only bedridden patients with healthy skin or skin reddened but without active pressure sores were included.

During the trials, which extended over 12 weeks, only 5 of 54 patients receiving this care, developed bedsores. Four of the five were elderly confused persons whose cooperation in treatment could not be obtained. For general use, the most effective preparation for the prevention of bedsores is silicone emulsion containing 20% silicone. The 15% emulsion is slower in action for cases showing early skin damage over pressure points, and the 25% emulsion causes somes initial aggravation in those cases with skin damage.

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People who have recently received Salk vaccine can give blood without any danger to themselves or the patient who will eventually receive this blood. This was announced recently by Dr. W. S. Stanbury, national commissioner of the Canadian Red Cross Society.

News of Red Cross, Vol. 7, No. 5, 1959.

* * *

She took to telling the truth; she said she was forty-two and five months. It may have been pleasing to the angels, but her elder sister was not gratified.

— Hector Hugh Monro

* * *

I am a part of all that I have met.

— Tennyson

Table of Antidotes

First — Send for doctor immediately. Keep the patient warm.

Second — Determine what substance has been taken if possible. Give specific treatment if poison is known.

Third — If the poison is not known and patient is conscious, give copious amounts of water.

Proceed to induce vomiting as in No. 4 if the poison is *not* a corrosive.

1. Headache and cold compounds, salicylates (Aspirin), rubbing alcohol, antifreeze, oil of wintergreen.	Give a mixture of two tablespoonfuls of powdered burnt toast, one tablespoonful of milk of magnesia, and four tablespoonfuls of strong tea. Induce vomiting by use of finger or tooth brush in throat. Follow by one tablespoonful of soda bicarbonate in warm water. Give strong tea or coffee.
2. Bleaches — chlorine.	Give one teaspoonful of aromatic spirits of ammonia in a glass of water. Hot coffee or strong tea plus one egg white.
3. Lye and washing soda.	Give two tablespoonfuls of vinegar in two glasses of water. Then two egg-whites or two ounces of olive oil. *Do not induce vomiting.*
4. Hydrocarbons (cleaning fluids, gasoline, kerosene, turpentine, carbon tetrachloride).	Induce vomiting with *a)* one tablespoon of mustard and warm water or *b)* soap and warm water or *c)* salt and warm water. Give four ounces of mineral oil, then hot coffee or strong tea.
5. Lead, paint, DDT, mushrooms, food poisoning, bromides.	Induce vomiting as in No. 4. Give two tablespoonfuls of epsom salts in two glasses of water. Then, large quantities of hot coffee or strong tea.
6. Barbiturates, sleeping medicines.	Give mixture as in No. 1. Induce vomiting. Follow with No. 5.
7. Morphine, opium, paregoric, codeine.	Give mixture as in No. 1. Then two tablespoonfuls of epsom salts in two glasses of water. Keep patient awake.
8. Belladonna and strychnine.	Give mixture as in No. 1, then give as in No. 4, induce vomiting. Do not restrict movements. Give artificial respiration if necessary.
9. Arsenic and "pep" medicines.	Give mixture as in No. 1 followed by No. 4.
10. Carbon monoxide.	Rush victim into fresh air. Make patient lie down. Hot coffee or strong tea. Artificial respiration if necessary.
11. Carbolic acid.	Give two tablespoonfuls of whiskey in eight tablespoonfuls of warm water. Then a glass of milk with two egg whites. Then hot coffee or strong tea.
12. Phosphorus.	Four ounces of hydrogen peroxide. One tablespoonful of soda bicarbonate in a quart of warm water followed by four ounces of mineral oil. *Do not use vegetable or animal oil.* Induce vomiting as in No. 4.
13. Sodium fluoride.	Give two tablespoonfuls of milk of magnesia, followed by a glass of milk. Induce vomiting as in No. 4.
14. Corrosives, acids.	Give one ounce of milk of magnesia in a large quantity of water. *Do not induce vomiting!*
15. Iodine tincture.	Give two ounces of a thick cornstarch and water paste. Then two ounces of salt in a quart of warm water. Drink until vomit fluid is clear, then give a glass of milk.
16. Camphor, powder from fluorescent tubes.	Induce vomiting as in No. 4.
17. Bichloride of mercury.	For each tablet swallowed give whites of two eggs in a glass of milk. Give mixture as in No. 1. Follow with one ounce of epsom salts in a pint of water.

Death from Plastic Film

FRED W. JEFFREY, M.D.

WE are now confronted with one more hazard, which is causing us increasing concern . . . *thin, pliable, plastic film.*

The use of plastic film has been gaining rapidly in popularity, due to its unquestionable advantages over other materials. Its protective qualities are unsurpassed and its transparency and durability make it ideal for its intended purpose. It will find a continuing application in the packaging of a wide range of consumer products — food-stuffs, clothing, house furnishings, even hardware and sporting goods. Plastic film preserves the life of merchandise, both in the store and the home, as well as food in the refrigerator and bread box.

There are, however, inherent dangers associated with its use. When thin plastic film comes in contact with the face it adheres, partially from the act of inhaling, which draws it tightly over the mouth and nose, and partially from the static electricity generated by the movement of the plastic film itself. Unfortunately, under these circumstances, one of its virtues becomes an additional hazard. The strength of the film makes it difficult for an enmeshed toddler to tear. If plastic film is not removed from an infant's face *within one minute,* the baby will die of suffocation.

The adhesion of plastic from static electricity is increased in a dry atmosphere. In Phoenix, Arizona, where the air is particularly dry, four deaths from plastic film were reported within a few weeks. After the tragedies, Dr. Paul B. Jarrett, chairman of the Maricopa County Medical Society Safety Committee warned:

> A child playing with a poisonous snake would not be in as much danger as one playing with plastic film, which clings with such diabolical tenacity. Such needless deaths can be prevented by keeping plastic bags away from young children.

As of August 1959, there have been 16 reported accidental deaths in Canada due to suffocation from thin plastic film. Of these, 15 occured in infants from six weeks to eleven months of age. In reviewing these infant deaths, we find that ten were due to plastic garment bags being used to cover mattresses of cribs or baby carriages; two were due to infants being allowed to sleep on cushions covered with thin plastic; three deaths were due to plastic bags being given to infants to play with by older children.

The urgent need for solving this problem is clearly indicated and the solution can not be better presented than in the resolution passed by the Canadian Pediatric Society at their annual meeting on July 24th, 1959:

> Plastic film as a cause of accidental deaths among infants and young children, should receive the same consideration as other hazards found in all Canadian homes, such as poisons, knives, matches, electrical appliances, etc.
>
> The need for a sustained educational program to instruct the public in its safe use is clearly indicated. Plastic film, after it has fulfilled its intended purpose, should be destroyed or stored in a place inaccessible to children.
>
> The advantages of plastic film have been so well established, that the prohibiting of its use does not seem justified.

The sustained educational program suggested in this resolution, has now been launched by the provincial safety organizations and Departments of Health and Welfare across Canada.

Banning of the products is certainly not warranted. Science, as it progresses, will supply us with more and more hazardous conveniences. We have been provided with automobiles, washing machines and wringers, electric appliances, effective but potent drugs, and now plastic film — all with their potential perils. We cannot be expected to do without these conveniences that are now accepted as necessities. However, it is our responsibility to understand the dangers associated with their use and learn how to guard against

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Dr. Jeffrey is chairman Ontario Medical Association Conference on Child Safety. This material has been prepared and distributed by the provincial safety organizations.

them. The following precautions in the use of plastic film are recommended:

1. Never use thin, limp plastic film such as used by dry cleaners for garments and blankets, as makeshift covers for crip and carriage mattresses or pillows. Special covers of heavy gauge plastic or rubber are designed for this purpose and are safe.
2. Keep thin plastic bags away from small children as you would matches or knives.
3. Explain to older children the danger of plastic film. Warn them not to place plastic bags over their heads and to keep them away from younger children. Because of the irresponsibility of childhood, it would seem preferable to keep plastic film away from all children.
4. When thin plastic film has served its intended purpose, it should be discarded safely by burning, using it to wrap garbage or tying it in a knot before throwing it in to the garbage container. If it must be kept for future use, store it in a place inaccessible to children.

Get Down to Brass Tacks—Prevent Home Accidents

IRENE M. ROBERTSON

YOU probably think of your home as one of the safest places in the world. Well, you are wrong! You are wrong because more adults and children have accidents at home than anywhere else. In fact, for children from 1 to 14 years of age, four out of every ten fatal accidents happen at home. Home, then, is where safety is needed most and where it should truly begin.

By eliminating known hazards and learning to do things correctly at home you will make your work easier and your home itself, a more pleasant, more comfortable and above all, a safer place in which to live. Learning and following safe habits at home will also encourage safety consciousness at work, while driving a car, while playing or while participating in other outside activities.

One of the main eflorts of Safety organizations is to make people home safety conscious. They are directing much effort toward cooperation with architects, builders, prospective home-owners and all builders, prospective home-owners and all agencies connected with home building, to have safety built into the home from the blueprint to the driving of the last nail.

Whose job is it to prevent home accidents? The housewife must act as the safety director in her own home, if she is really going to keep herself and her family free from injury and free from the pain and financial hardships that so often accompany accidents.

Can the housewife do the job alone? No. She, like the safety engineer in the plant, will need the cooperation of others. Her husband can help by making necessary repairs. The children can help by picking up their toys, putting away their bicycles, etc. In other words, the entire household must be safety conscious.

Most people are in such a frantic rush these days that safety principles are likely to be ignored unless everyone is made aware that the safe way of life is the proper way. That safety practices in the home are incontestably important is revealed by the figures of the American National Safety Council. They estimate that annually:

32,000 are killed accidently at home
130,000 are permanently injured
4,750,000 are maimed, disfigured or disabled

These figures are further broken down to show that:

16,000 are killed by falls
5,600 are killed by burns or explosions and fires
2,000 suffocate
1,500 are poisoned
1,200 die of firearms accidents
1,000 asphyxiated
4,700 killed other ways

It is also interesting to note, that

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in the age group below five years, one out of three accidental deaths is due to poisoning and one out of three deaths is due to burns. Even with these appalling statistics most people are probably provoked to murmur "Think of that" or "What a shame!"

Nurses have a big job to do because it seems that we are prone to be forgetful about home accidents and to take home safety for granted. Traffic accidents make the headlines in the news along with drownings, major fires, train and plane crashes. Yet homes quietly go on piling up the most appalling record for needless death, pain and sorrow, worry and expense. We continue to think of those accidents as always happening to others, until a member of the family is hurt in the apparent safety of our home. Then we wake up to the need for day-by-day carefulness and attention to hazards.

Let us start with the protection of children. Often *a child's unhappiness or lack of self-confidence may be the underlying cause* of a series of what appear to be simple mishaps. The child who is disturbed and unhappy may express his feelings unthinkingly in the form of hurts and injuries to himself. It is most important that parents make sure their children are free from undue worry or tension. If a child is getting more than his normal share of cuts, burns, scrapes and falls, look for a cause and try to remove it with as much care as would be used in safeguarding him against infection or illness. Factors other than mere chance, or awkwardness resulting from the poor muscle coordination of the physically handicapped, may be to blame for a history of repeated injuries. It seems likely that the child who has unusually frequent accidents may well grow into an adult who is "accident prone" and the bane of the safety department.

It is vital for parents to see that their homes are free from conditions which prove unsafe and to give their children adequate safety instructions.

Children are imitators. No amount of safety education can be completely effective unless mother and father obey the rules. Telling Johnny to cross the street only when the light is green is not going to seem important to him if he sees his dad dashing across on the red light. If he sees mother use a wabbly chair to reach into the cupboard instead of a ladder or other sturdy support when she needs to reach for something, it will simply seem silly to him to be told not to climb up to the cupboard. If parents make sure that their way of doing things is safe they will have the satisfaction of seeing their children take pride in acting as they do. Children are imitators and adults must be proper models for them.

Children are investigators. As an integral part of their growing-up process, children need to touch, to feel, to investigate. Many of these activities can be dangerous if they are unsupervised. Parents should try to direct the child's curiosity into safe channels. A start can be made by seeing that matches, sharp knives, cleaning fluids, etc. are locked up. Children are drawn to electrical outlets and fixtures like bees to honey, with the resultant danger of shock or fire.

Since pots and pans on a stove are potential hazards in the kitchen, the handles should be turned to the back. Such a simple procedure may prevent a severe burn. The bathroom is another dangerous place for inquisitive children and all are inquisitive. Always throw away what is left of no-longer-needed medicines. Get rid of used razor blades. Never leave a young child alone in the bathtub even for a few minutes. He can drown while you answer the doorbell or the telephone. In the bedroom small scatter rugs should be secured. The baby's crib should have its sides securely up. In the yard, clotheslines should be high enough to prevent a child from running into them. Garden tools should be put away and not left with the sharp edges turned up. If garbage is being burned in an incinerator children will be there to investigate. Watch them until the fire is out.

Young children should never be left alone in the house. Accidents which are very minor in nature when an adult is present can become tragic when there is no grown-up around. If a "baby-sitter" is employed take a few minutes to explain the simple rules of safety before leaving her in charge. Give her a telephone number where a responsible person can be reached.

On the streets and sidewalks parents cannot foresee or control all the hazardous situations that children can encounter. They can feel certain that their children are less likely to have serious accidents if they have created an environment where safety is practised at home.

There are some common hazards that can endanger any of us. Let us start with the outside porches and stairs. Many of the home accidents occur here and most of them are falls. There should be good, clear lighting. If there are more than two steps to the porch or entrance a handrail is added safety. A roof or canopy is useful protection over the porch and steps from snow and ice.

One building practice that has been too prevalent is the designing of stairs and banisters for eye appeal rather than protection. The upright balusters of the banister should be close enough together to prevent a child from pushing his head or sliding through. Other common stairway hazards especially of the attic and basement stairs is insufficient head room. Stairs with torn carpets edges and any articles left on the steps will cause painful bumps and falls. Every inside stairway should be well lighted and there should be a two-way switch in order to have light before starting down as well as before starting up the stairs.

Another important room is the kitchen. Though the way to a man's heart may be through his stomach it seems that the way to a woman's "hurt" very often follows a route through the family kitchen. Accidents here include burns and falls. There is much that can be done in the arrangement of space and equipment to safeguard the members of the family. The stove should not be placed too close to a window or door, where they commonly are to be found. With a gas range there is danger that the flame will be extinguished by drafts or the window curtains blow across the burner and cause a fire. Sliding doors on the cupboards instead of those that open out into the working space is one way to avoid a bump on the head. All too often, cupboard space is too high, so that you are tempted to climb on a kitchen chair or pull out a lower drawer to stand on with the risk of falling. Fortunately, the modern trend is toward lower and more accessible cupboards which is an encouraging sign.

Careful consideration should be given to the lighting in the home with a sufficient number of electrical outlets. Electric switches ares safer than pull chains. Never turn on a light with one hand while touching a faucet with your other hand. It is better protection not to have switches near a sink. This principle also holds true in the bathroom. Faulty wiring and improverished cords, carelessness with cigarettes, dirty furnaces put into winter operation and storage rooms full of rubbish, all contribute to our high fire statistics. Many people use gasoline or lighter fluid to remove spots from clothing, or as a general cleaner for machinery. Gasoline is one of the most dangerous fluids that can be used around the home. It evaporates readily and the vapor it forms explodes easily. Another cleaning fluid often used is carbon tetrachloride which is a highly toxic chemical. In industry, safe methods for controlling the danger from this liquid are practised, while in the home many people do not realize that the poisonous fumes from this chemical can prove fatal unless there is ample ventilation to carry them away. The safest precaution is not to use carbon tetrachloride or any cleaning compound to which it has been added.

Packages and bottles in the medicine cabinet should be clearly labelled in order to prevent mistakes. A band of adhesive around bottles containing poisonous drugs will serve as an added reminder that they are dangerous substances. All labels should be clean and read three times before taking the drug.

It is advisable to have a fire extinguisher in the home but not one containing carbon tetrachloride. The older members of the family can be instructed how to use it safely. The extinguisher should be placed on a wall, well out of the reach of small children.

A first aid kit is another valuable asset in the home. It need not be elaborate. Any metal-type box with a lid could be used. Some suggested contents for kits are: adhesive tape, gauze pads, gauze bandages (2" and 3"), band aids, a mild antiseptic, an oint-

ment for minor burns and a pair of good tweezers for removing slivers. Choose a drawer or cupboard in the kitchen where the kit will be readily available.

Periodic surveys of the home from the basement to the roof, are most important in order to find existing dangers and eliminate them. If common sense is used towards health, safety habits, and anticipation of certain hazards with correct precautionary measures taken against them, then home can truly be a sanctuary. It need not and it should not, be a place of potential danger. Remember, the life you save may be your own or that of one of your loved ones.

Hospital Housekeeping

R. N. Wickens

Hospital housekeeping is the care and maintenance of the inside of the hospital, its furniture and equipment. Housekeeping functions for hospitals must produce the utmost cleanliness and be well planned in order to control infection. The day of the "man and a broom," or "maid and a mop" is gone. Scientific planning is as important in this field as in other administrative functions.

In order to achieve the most effective results, housekeeping must be directed from the administrative level. The housekeeper should be responsible to one person — preferably, the administrator. If the housekeeper is to have undivided authority, then the selection of the right person is of utmost significance. It is essential that he have a complete knowledge of building and equipment cleaning and maintenance procedures, as well as knowledge of disinfection methods and products, and public sanitation. He will need a mastery of the art and skills not only of administration, but equally important, of teaching. He must develop a close association with the bacteriology department and other department heads in order to ensure the development of proper techniques and products as they apply to the various hospital areas. It is important that a goal of all persons in executive or departmental authority be that of a clean building and furnishings and that they have an understanding of the role of the housekeeping department in achieving this goal. Without this, the value of all other measures of infection control are sharply reduced in their effectiveness.

Mr. Wickens is Administrative Housekeeper at the Montreal General Hospital.

Ways and Means

In order to keep the hospital clean and simplify planning, the building can be divided into specific functional areas, such as offices, kitchens, patient rooms, operating rooms, etc.

Regular general cleaning techniques for offices, stock rooms, corridors, kitchens, dietary and laundry areas, comprise daily dry or damp dusting of furniture and equipment. (Floors are discussed under "Special techniques for floors.") Air vents and radiators should be cleaned both inside and out, quarterly, as well as ceiling lights and other high dusting and damp mopping areas.

Annual cleaning, and more often if necessary, consists of washing of walls, ceilings and windows, with reduced attention to window cleaning in the winter. The exception to the above rule, is that the kitchen and dietary areas have this annual-type coverage, quarterly, and that all kitchen utensils and culinary equipment be cleaned by dietary and kitchen staff.

Patient Rooms — Non-infected

Public and private wards and general treatment areas which are non-infected, require regular daily cleaning as outlined for patient areas. Permanent and mobile equipment, and furnishings should be damp-wiped. Pa-

tients' rooms require complete cleaning annually or more frequently as required, as well as special cleaning of individual "check-out" units in multiple bed rooms or complete cleaning of single rooms. Toilets should be cleaned twice daily.

Preventive disinfection cleaning of dressing and treatment rooms on wards should be done daily.

Preventive Disinfection Housekeeping

Operating rooms, obstetrical units, nurseries, outpatient department, surgical dressing and treatment rooms: Regular routine cleaning of all surfaces is to be done after each non-infected case, including damp or wet floor mopping. Every night all surfaces should be wiped down and floors cleaned (see "Special techniques for floors.") There should be a four-week rotation special cleaning of all surfaces, air vents and radiators (see "Specific technique for eliminating air-borne bacteria.")

Laboratories, x-ray, pathology, bacteriology and similar areas require the same daily, quarterly and annual coverage as previously cited for offices. A special program of equipment and work area cleaning, as carried on in the O.R., should be done in these areas daily and on a four-week rotation basis. Full scale disinfection should be carried out after use for an infected case.

Occupied Infected Rooms and Wards

First, loose dust should be removed with an adequately equipped vacuum cleaner. Floors should be damp mopped daily. Furniture, bed-frames. and permanent and mobile equipment, damp-wiped or washed also daily. Toilets, pictures and cupboards should be cleaned twice daily. Weekly, toilets should be done with Aerosol Fog, and air vents and radiators cleaned inside and out (for detail see Aerosol). The last act of daily cleaning is the elimination of air-borne bacteria by vacuum in one to four-bed, but no larger, rooms, with the doors and windows closed. All mop-heads and rags used for cleaning, should be left in the soiled isolation linen bag in the infected room. Regulation isolation clothing is to be worn, once only, in each room and also left in the isolation linen bag. All cleaning equipment should be wiped down with disinfectant before taking it out of the room or ward.

For individual infected cases in multiple bedrooms that are not fully isolated, furniture, equipment and toilets, should be washed or damp wiped daily. This patient arrangement should be avoided if at all possible, by transferring the patient to an isolation room or ward.

Vacated Infected Rooms and Wards — Final Disinfection

At check-out and when infection is ended all disinfection housekeeping in infected rooms should be done by a specially trained isolation housekeeping team. After the room is vacated or during a temporary absence of the patient from the room, it should be closed by the charge nurse. No bedding, mattress, furniture or equipment should be removed. The Aerosol Fog is sprayed on the room, the ward toilet, and all their contents (see following, "Specific techniques for eliminating air-borne bacteria.")

In multiple bedrooms that are never fully vacated, all walls are washed down monthly. Floors are damp mopped daily and the linoleum rewaxed quarterly or oftener if required. Buffing may be dispensed with if emulsion (no buff) resin finishes are used. Complete stripping and rewaxing can only be carried out when the ward is completely empty.

Special Technique for Floors

Dry sweeping and dry mopping are not used in patient areas, operating, treatment or special sterile areas. They may be used in business, stock room and other non-treatment areas with or without use of dust control treatment, sweeping compound, or treated sawdust. Clean, laundered mop-heads should be issued to start the day and more often if necessary.

Dry vacuum machines are used in conjunction with wet or damp mopping to remove in advance all surplus dust in all hospital areas, including infected rooms. Specially adapted machines should be used, with the supplementary filters being changed twice weekly in non-infected areas, and at least daily in infected areas. For

daily room vacuuming by maids, a specially constructed machine with supplementary filter and sealed disposable dust bag should be used.

Wet and damp mopping of hard floors should be done daily or oftener, and scrubbing done at least weekly, daily in heavy traffic areas. Linoleum should be damp mopped and buffed weekly in non-infected patient rooms and all general areas if emulsion buffing wax finishes are used.

Water vacuum pick-up should be used for pick-up of scrub water, whenever possible, if an automatic scrub combine is not used. Disposal of soiled solution from the pick-up tank should be done at frequent intervals. In isolation or other infected rooms or wards, disposal is carried out in the toilet in the room, or in adjoining cleaners' cupboards. Each time the disposal area is used it should be well cleaned and disinfected. At frequent intervals there should be a change of solution in ordinary patient and other rooms, and fresh solution used for each isolation room.

In infected rooms, use a damp mop only on the hard or linoleum floors, wax linoleum and do not buff. Clean laundered mop-heads are necessary daily, using a different clean one for each infected room or ward. Use of mops for wet mopping can be kept to a minimum where auto-combine and wet vacuum pick-ups are used in conjunction with scrub machines.

Linoleum Floor Resurfacing

In ordinary traffic areas, the floor should be damp mopped and buffed, weekly. Quarterly, it should be refinished as required, or stripped and rewaxed. In heavy traffic areas, corridors require daily mopping and buffing, weekly refinishing, and monthly stripping and rewaxing. Water wax emulsion (no buff resins) should be used for resurfacing linoleum in all nursing unit areas, including non-infected patient and treatment areas.

If all areas are not so treated, synthetic emulsion resin wax is best for resurfacing linoleum in infected areas, as it requires no buffing. If there is an isolation ward or individual room used for no other purpose, synthetic wax is recommended. It will damp mop to a reasonable finish without buffing and can be resurfaced by adding a coat or more of the product. There is a danger of "build up" in all floor finishes, in which bacteria may be imbedded. A periodic strip and rewax must be carried out. This does not apply to water emulsion wax to the same extent, as repeated moppings remove the wax more quickly than the synthetic, and it must be renewed oftener. The water wax surface requires buffing, however.

For hard floor (terrazo, cement) resurfacing use an emulsion resin, and because it gradually washes away, renew at periodic intervals. It never creates a traffic path, resists absorption of stains and dirt and makes floor maintenance easier. Always scrub the floor clean and disinfect before applying the product.

Conductive floors of operating room, etc., must be washed, mopped or scrubbed with a nonsoap base germicidal detergent solution to prevent build-up film which would destroy conductivity and would undoubtedly contain dormant bacteria. The floor must be washed after each case, with a clean mop, used once only. Every day, preferably at night, the floor should be scrubbed by machine, soiled solution picked up by water pick-up vacuum or automatic combine and disposed of in hopper sink in, or adjoining the area being cleaned. Clean solution and mops should be used for each room. Use of mops can be kept to a minimum by use of autocombines and wet vacuum pick-ups used with scrub machines.

Paste or spirit-based liquid wax is expensive and difficult to lay, maintain and remove. Spindle oil, glycerine, etc., is recommended by many specialists as a control factor for bacteria and infection from dust and other droppings. Its usefulness must be determined by "in use" tests in areas such as O.R.'s, treatment rooms, and infected patient rooms and wards. One essential would be a frequent stripping of the floor, followed by reoiling. A problem is presented from the standpoint of general appearance and tracking to other areas. It would probably be most effective in single rooms used only for infected cases or separately located isolation areas of considerable size. I have never used this method.

Mops and rags used in infected

areas should be taken out of these areas in isolation linen bags. These should be used once only in one room, and laundered and disinfected before re-use.

Eliminating Air-borne Bacteria

The Aerosol spray is used in preventive housekeeping disinfection and final disinfection. It is not to be used while the patient is in the room. When used, there should be a primary fogging and a final fogging when the work is done. In the O.R. use only a monthly rotation fogging for preventive housekeeping disinfection and after known infected cases.

The vacuum machine should have specially constructed primary filters and supplementary filters that further prevent dust escape and also disperse the exhaust, thereby preventing disturbance of dust elsewhere in the room. It can be used in occupied and unoccupied rooms whether infected or non-infected. Doors and windows should be closed during the process of air filtration. Run it for twenty minutes in an ordinary sized room. There is little to be gained by use in large multiple bed wards.

Aerosol fog and the vacuum machine can be combined for air filter and disinfection and used during final "check-out" cleaning of isolation and other rooms, including O.R. and treatment areas, but not in occupied rooms. Aerosol fog the room first, then after a 20-minute wait start the cleaning program. Have vacuum running during the entire period to filter bacteria-laden dust in the air caused by the movement and work of cleaners. Run it again for 15 minutes on conclusion of cleaning. No one should remain in the room, and doors and windows should be closed. Give the room a final Aerosol spray. The room will be ready for reoccupancy in an hour. A greater use of the Aerosol spray during occupancy would be possible if the disinfectant used could be non-toxic and non-irritating, but fully lethal in effect.

Ultra-violet disinfection for air-borne bacteria and general housekeeping disinfection should not be overlooked, but it has many limitations.

Radiators and ventilators in patient isolation rooms and other infected areas should all be carefully cleaned and disinfected inside and out. This should be done at each patient "check-out" or room closing and during uninterrupted occupation at least once every four weeks. If these places become dust-laden, they undoubtedly add to air-borne infection because bacteriological tests of dust prove them to be heavily contaminated with pathogens.

Refuse Pick-up and Disposal Procedures

Special methods should be planned for the entire program for all hospital areas and particular care taken in the removal of refuse from infected rooms. Caution must be exercised in sealing adequately in a paper or polyethylene bag, all refuse from infected rooms before placing in refuse containers for pick-up by the refuse team. Swill cans, for swill and other wet substances, should be washed, disinfected and steam sterilized each time they are emptied. Dressing cans require the same treatment once a week. Isolation and other infected room cans should be given the above treatment at patient "check-out," on completion of occupancy and whenever a can is changed while, for non-infected areas, this should be done every two weeks. Dressing cans and cans from infected rooms should be taken to the garbage room in cotton bags, where they are emptied and sterilized.

Normal ordinary refuse in all areas should be collected in cotton bags on janitor carts which, when they are full and carefully closed, are placed in cleaners' areas for pick-up by the refuse team. Each maid or cleaner should be supplied with sufficient clean cotton bags each morning. Bags are used for only one filling and are to be laundered before re-use. Swill cans are to be picked up after each meal, the full can replaced, then taken away to be emptied and sterilized. All refuse from isolation and other infected rooms should be separately and securely sealed in paper or polyethylene bags, and placed in regular collection cans. Isolation cans are kept in each infected room. Dry refuse, filled polyethylene and paper liner-bags, and all wet or dry refuse from infected rooms is burned in the incinerator. Unburnable refuse is taken by the garbage collector, with the exception of infected refuse

which is incinerated and taken away with ashes. Polyethylene or paper liner-bags of good wet-strength are used only for isolation, treatment rooms, O.R.'s, utility and dressing rooms, and laboratories for wet or moist refuse. The paper bags are closed on pick-up and taken away in a covered carrier. Before the refuse team leaves the floor they reline the cans.

An experiment has been completed with polyethylene liner-bags for cans. They are satisfactory and are no more costly than paper and are disposable. They can be closed more tightly to prevent escape of dust.

Mattress Sterilization

Known or suspected mattresses at "check-out," are transported in sealed canvas envelopes after having been sprayed or wiped with disinfectant. They should be gas sterilized before re-use. Envelopes are used only once to transport them and then laundered before re-use. If gas or other sterilization is possible, it would be advisable to have a six-month rotation disinfection of all presumably clean mattresses. This method is currently under investigation.

Curtains and Blinds

Bed, shower and bath curtains in single rooms or individual bed curtains in multiple-bed rooms should be changed at "check-out," in an emergency, and not less than every two weeks in non-infected rooms. In infected rooms these should be changed at least once weekly. Window curtains in non-infected rooms should be washed quarterly, in an emergency and certainly at the end of each occupancy by an infected patient. Venetian and pull blinds should be cleaned annually if enclosed between panes and weekly if not enclosed; daily in infected areas. In non-patient areas, monthly is sufficient.

Bed Blankets

These should be changed for each new occupancy, laundered and disinfected for re-use. For continued occupancy change blankets weekly, and oftener in infected rooms. I would recommend Acrilan or a similar synthetic wool blanket that will withstand repeated laundering at prescribed temperatures. They can tolerate much higher temperatures than pure wool. Spare wool blankets used for bed throws may be wrapped in low cost disposable polyethylene envelopes. While sealed they remain sterile, so there is no need to launder them unless they are opened.

Isolation Clothing

Housekeeping staff working in infected rooms wear regulation isolation clothing, which includes a cap, mask, gown and overshoes. Clean clothing is used for each room. After use it is placed in the isolation linen can in the infected room.

Further Suggestions

Investigation should be made and consideration given to the possibility of procuring synthetic sponge rubber floor tools with water-squeezers attached or a separate squeezing unit. Nylon strip mop-heads also can be used. These resist retention of dirt and bacteria if properly washed and rinsed in disinfectant after each use. These take the place of string mops for wet-washing or damp wiping of all floors.

Investigation should be made into the possibility of procuring wet-strength paper dusters and wipers for both dry and wet wiping processes at a cost allowing disposal in refuse cans after use. This would be particularly good in infected areas because they could be destroyed before there was any possibility of use elsewhere.

In conclusion, careful investigation and testing should be carried out on all modern mechanical and other special equipment in conjunction with the bacteriologist and other professional medical personnel. All cleaning must include coordination of thorough scrubbing, mopping, washing and wiping, and good old fashioned "elbow grease."

In England we have come to rely upon a comfortable time-lag of fifty years or a century intervening between the perception that something ought to be done and a serious attempt to do it.

— Herbert George Wells

Pneumonia

ELEANORE DE LA MARE

PNEUMONIA is an infection of the lung which results in inflammation. It may be classified according to the type of invading organism or according to the location in the lung, i.e. pneumococcal, streptococcal, viral or lobar, bronchial etc. Usually, the lung is able to defend itself against air borne infection due to extraordinarily efficient defense barriers in the respiratory tract:

1. the epiglottis reflex
2. the sticky mucus that lines the bronchial tree and traps microorganisms
3. the cilia of the respiratory epithelium which keep the infected mucus moving constantly upward toward the pharynx
4. the cough reflex
5. the lymphatics which drain the terminal bronchi and bronchioles
6. the mononuclear phagocytes which are ever-present in the normal alveoli
7. the alveoli are normally dry and so provide a poor growth medium for bacteria.

The nature of the infection will depend upon the balance between the contending forces: the susceptibility of the host, and bacteria, chemicals and viruses.

Susceptibility

The susceptibility of the host is increased by:

1. exposure to wet and cold
2. fatigue, malnutrition, chronic alcoholism
3. overcrowding
4. immaturity — in young children it may be associated with measles, whooping cough, etc.
5. anything that interferes with the cough reflex (anesthesia, unconsciousness, fractured ribs or severe chest injury, upper abdominal surgery)
6. debility associated with old age, cancer, chronic heart disease or renal disease.

Causative Agents

In *lobar pneumonia* — pneumococcus Types I, II, and III and occasionally Friedlander's bacillus.

In *bronchopneumonia* — usually a sequel to spread or inhalation of bacteria from some upper respiratory source, e.g. streptococci, staphylococci, B. *influenzae*: vomitus or other foreign material, especially following atelectasis or partial collapse of a lung.

Lobar Pneumonia

Pathology: The virulence of Types I, II, and III pneumococci is so high that the predisposing causes are of less importance than in infections with most other bacteria. The pneumococci invade the alveoli and an inflammation results. The alveolar walls become thickened owing to congestion and edema, and the alveoli themselves become filled with an exudate containing fibrinogen and red cells. These stages are known as engorgement and red hepatization respectively and are followed by the stages of grey hepatization (white blood cells present in exudate) and resolution. The stage of resolution, owing to the diminished blood flow, reveals a diminution of blood-borne anti-enzymes. Later, the ischemic anoxia means a rising acid reaction in which macrophages enter and are more active. The alveolar contents slowly disappear by solution, phagocytosis and expectoration.

Signs and Symptoms: Lobar pneumonia has an acute onset of chills and fever (often 102° to 104°F). The face is flushed and *herpes febrilis* is comconly present on the lips or cheek. The respirations are rapid and the nostrils may move with respiration. This sign denotes a fairly serious disease of the respiratory system. The pulse rate rises, but not in proportion to the rate of respirations.

In a day or so the cough becomes moist with typical "rusty" sputum, which is thick and tenacious.

Physical examination reveals alterations in the breath sounds over the consolidated lobe which may be detected readily with a stethoscope. X-ray examination shows the infected lobe to be a dense shadow.

Treatment: The specific treatment

for lobar pneumonia is chemotherapy with antibiotics: penicillin, sulphonamides or one of the tetracyclines. The drug should be continued until the temperature has been normal for a few days. The symptoms are usually severe for only two or three days excepting in infants and elderly people who may not respond well in spite of specific therapy.

Complications: Due to consolidation of one or more lobes pulmonary circulation is handicapped, causing overtaxation of the right ventricle. Cyanosis may accompany the dyspnea and severe attacks of delirium may also occur.

The pleura lining the affected lobe, may be inflamed causing one form of pleurisy. This condition is suspected if there is severe pain in the chest on inspiration. The cough becomes short and suppressed, as it causes pain.

Empyema, a more serious complication, is the effusion and accumulation of purulent exudate in the pleural cavity.

Bacterial invasion of the blood stream can cause pericarditis, meningitis, peritonitis, arthritis, or acute bacterial endocarditis.

Toxicity plus anoxia endanger life by causing generalized capillary injury, myocardial degeneration, peripheral circulatory failure and death.

Bronchopneumonia

Pathology: Bacteria of less virulence than pneumococcus Types I, II, or III are commonly found in the mouth and upper respiratory passages of healthy people. Given the necessary predisposing factors infection may occur, often following bronchitis. The result is a number of irregularly scattered nodules of pulmonary consolidation, known as bronchopneumonia. There are two forms of consolidation:

1. Because the bacteria are less virulent than pneumococci, there is less over-all reaction when they enter the alveoli. The groups of alveoli affected are those immediately surrounding the inflamed bronchiole. These areas are like nodules embedded in soft lung tissue.

2. When other small bronchi and bronchioles become occluded by thick mucus, the air imprisoned in their aveoli soon become absorbed and the area collapses. These are dark blue, collapsed areas and contrast with the more bulky consolidated inflammatory nodules.

Both lungs may be affected — the lower lobes more than the upper — and the nodules may vary from the size of a pea to large areas formed by coalescence of many nodules, perhaps a whole lobe.

Signs and Symptoms: Since the causative agents of bronchopneumonia vary widely, the forms that the disease takes also vary; e.g., hemorrhagic, edematous, purulent and fibrinous. In general, the onset is less acute than in lobar pneumonia, with less fever. There is usually no associated pleurisy, but there may be a more drawn-out course and it is more apt to become chronic.

Treatment: The treatment is the same as for pneumococcal pneumonia but the antibiotic should be of the type that is specific for the organism. Isolation of that organism may be difficult through sputum specimens because staphylococci and streptococci are normally present in the nasopharynx.

Complications: Irreversible damage to the lung resulting in multiple abcesses, bronchiectasis, and pulmonary fibrosis may occur.

Nomenclature in Bronchopneumonia:

Chemical — following inhalation of poisonous gases in industry or warfare.

Hypostatic — chronic cardiac disease, marked debility or coma.

Postoperative —

1. Aspiration pneumonia, following inhalation of septic or vomited matter under anesthesia or following surgery.

2. Mild infection of segments of lung following blocking of tubes by excessive secretion of mucus during anesthesia.

3. Following septic pulmonary emboli.

Interstitial Pneumonia

Pathology: The viruses of measles, influenza, whooping cough, and virus pneumonia produce a different reaction in the lungs, namely, an acute inflammation of which the outstanding features are: an exudate that is much more marked in the interalveolar walls than in the alveoli themselves. There is a preponderance of the lymphocytes

and plasma cells over polymorphonuclears.

The infection begins in and is usually confined to the upper respiratory passages, but may spread to the bronchioles and alveoli as described. The picture is always complicated by secondary invasion by bacteria (B. *influenzae*, streptococci, staphylococci) which are responsible for purulent exudates into the bronchioles. The result is bronchopneumonia, abscess, gangrene, empyema etc.

Signs and Symptoms: The symptoms are like those of lobar pneumonia, but the signs are conspicuous by their absence. Diagnosis may be made following the lack of response to penicillin and the sulphonamides. The virus pneumonia about which the most is known is called *primary atypical pneumonia*. It is probably caused by a virus, although it has not been identified. The disease tends to occur in sporadic form, but many localized outbreaks have been reported. It was more common among the armed forces in World War II than all other forms of pneumonia.

Signs and Symptoms: Characteristically there is more or less extensive patchy bronchopneumonia with areas of hemorrhagic consolidation. Localized atelectasis or emphysema may be present as the result of bronchial obstruction.

The onset is usually gradual. Symptoms of general malaise with fever, cough, headache, chilly sensations are non-distinctive. The cough is the most significant, dry and paroxysmal at first, productive of mucoid or muco-purulent sputum, later. Temperature is within the same range as in lobar pneumonia. Fine or medium rales are usually present and may be the only abnormal sign. The duration of symptoms is variable, sometimes lasting for three weeks, with the temperature falling by lysis.

Treatment: Recent studies have indicated that aureomycin has a curative effect on primary atypical pneumonia. It should be continued for three days after the temperature has returned to normal. Another tetracycline (terramycin) has been reported to be effective as well as chloramphenicol.

Complications are relatively uncommon, and the prognosis is excellent.

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There has been much criticism in recent times of our present-day youth. You will agree that there have been instances of indiscipline and lack of ideals which are a cause for regret and shame. Steps must be taken to check these evils, but this cannot be done by mere commands or exhortations. We must find out the causes of such unrest and take steps to remove them. I am convinced that if at times the young are restless and turbulent, it is not due to any intrinsic defect in them. Their restlessness is largely due to the fact that they do not have enough channels for the expression of their youthful urges.

The problem of discipline must be looked at from the point of view of the proper utilization of the abundant energy of youth. If youthful energies and urges are canalized and fields are found which will use all their enthusiasm and devotion, there will be little occasion to impose restrictions from above. Discipline must be achieved by giving proper direction to the energy of the youth and not by suppression.

— Maulana Abul Kalam Azad

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Marlex linear polyethylene is capable of withstanding a temperature of 250°F. at 15 pounds per square inch steam pressure for 20 minutes or more. Such products as emesis basins, water pitchers, culture tubes, filtering funnels and beakers are in use. For further information write to: Phillips Chemical Company, Bartlesville, Okla.

* * *

Wisdom is never dear, provided the article be genuine. — Horace Greeley

Right Lobar Pneumonia

AMARYLLIS EATON

AT 4:00 P.M. on a pleasantly warm day Mary Duval, 15 years of age, came to the emergency department. She stated she had pain in her right chest which had developed suddenly the night before together with a feeling of being generally ill. Although she was wearing a heavy jacket, she was very chilly. Her temperature, pulse, and respirations were increased indicating the presence of infection accompanied by a chill. Because of these findings Mary was admitted to the hospital and placed on a medical ward. Once she was settled the following history was obtained.

History

Mary had had a very unhappy childhood. Her parents are separated, her father's whereabouts are unknown, and her mother is frequently intoxicated. Mary said she was relieved when she was made a ward of the provincial government. At her request the Child Welfare Department placed her in a private foster home.

In October 1956, Mary had stepped off a city bus into the path of an oncoming car and had suffered a severe compound fracture of her right leg. This accounted for a previous admission to the hospital. The wound had become infected so she had been hospitalized for over a year. Having become accustomed to hospital routine, she knew that to receive treatment she had better get herself admitted since her foster parents refused to believe she was ill.

Symptoms

Subjective symptoms described by the patient were:

1. A dry, non-productive cough for nine weeks.
2. Sudden feeling of being ill.
3. Rightsided chest pain for one day on deep breathing and coughing, with raising of small amount of sputum.
4. Feeling of being chilly, then hot, for the past 24 hours before coming to hospital.
5. Headache, anorexia, aching of muscles and other symptoms of general malaise.

Objective findings were as follows:

1. Temperature, pulse and respirations were 104.6° - 120 - 28. The body was reacting to the presence of infection with resultant high temperature and pulse rate. Respirations were rapid because the basal lobe of the right lung was not being aerated, and shallow because of pain.
2. Physical examination revealed dullness and decreased breath sounds over the right lower lobe due to exudate filling the alveoli.
3. Chest anterior-posterior x-ray revealed an area of density at the base of the right lung giving the appearance of pneumonitis. Remainder of the lung field was clear.
4. Blood culture revealed the presence of the Diplococci *pneumoniae.*
5. White blood cell count was 14,650 per cu. mm. The normal is 5,000 to 10,000 per cu. mm. This indicated the body's reaction and attempt to control the infection caused by the organisms.
6. Sedimentation rate was 54, revealing that an inflammatory process was taking place (the normal is 0 - 15).
7. Hemoglobin was 10.5 gm/100 cc. of blood or 72% (normally it is 11 to 15 gm.) This was indicative of some anemia.
8. Hematocrit was 32% (normal is 37 to 47%). This indicates a lowered number of red blood cells per unit of circulating blood.
9. Sputum from the lungs sent for routine culture and antibiotic sensitivity examination revealed no evidence of Diplococcus *pneumoniae* or unusual flora in three specimens. This was perhaps due to the sputum not being produced from deep in the base of the right lung.

Nursing Care

Mary was admitted to the ward by wheel chair, immediately screened, helped to undress, and put to bed. She was placed in semi-Fowler's pos-

Miss Eaton is a recent graduate of the School of Nursing, University of Alberta Hospital, Edmonton, Alta.

ition to ease dyspnea, and ordered on complete bed rest, the aim of which is to ensure rest physically, mentally, and emotionally thus permitting the body to combat infection and promote faster recovery. Her temperature, pulse, and respirations were taken every four hours to reveal chills and to assess the course of the disease. Since she appeared so ill she was not weighed, but stated her weight was 115 pounds.

Though Mary felt very chilly, her skin was hot to touch; extra blankets were applied. A tent was erected over the head of her bed, into which steam was running continuously. The purpose of the steam was to help loosen the thick, tenacious sputum and thus promote expectoration. It also soothed irritated mucous membrane.

Since no cyanosis of lips or fingertips was observed, oxygen was not required. An immediate sputum specimen as well as a specimen of blood were obtained; both were sent for culture and antibiotic sensitivity for the purpose of determining the infective organism.

Chloromycetin 500 mgm. was given every six hours orally for three doses, then continued with 250 mgm. every six hours for 29 doses to produce antibacterial activity against the organisms. S.R. Penicillin, 800,000 units was given immediately, followed by 800,000 units every six hours for seven doses. The order was then changed to 800,000 units intramuscularly twice a day for 14 doses. This drug possesses bacteriostatic and bactericidal action against gram positive organisms. To produce antipyresis, to relieve headache, and to ease muscular aches and pains, two analgesic tablets were administered every four hours as necessary.

A paper bag was pinned to the bed for the disposal of celluwipes. Mary was instructed to cover her mouth while coughing to reduce the risk of contagion. A sputum cup was not supplied since copious amounts of sputum were not produced and celluwipes were sufficient. She was encouraged to drink as much as possible to correct dehydration, to lower her temperature, and to promote urinary output thus preventing toxic substances from collecting in the body.

Instructed not to get out of bed, Mary used her call bell pinned at the head of her bed when she required a pan. Since she felt very weak her hands and face were washed by the nurse and she was aided in eating. A soft diet was ordered, since it was easier to eat as the patient was weak and her appetite was poor. It provided carbohydrate and protein, and was of a high caloric value.

By that evening, the temperature had dropped to 100.2° due to the action of the medication and the forced fluids. The patient was feeling much more comfortable. If the temperature had not fallen, a cooling sponge would have been given. She was coughing harshly and perspiring profusely. The bed linen was changed, flannelette sheets being used to promote comfort and absorb moisture. Care was taken to see that all windows were closed and no draught was blowing during the procedure. Her headache and muscular pains were relieved by the analgesics. Fluids were encouraged, taken well, and recorded.

Mary was given mouthwash, had her face and hands washed, her bed linen again changed, her back rubbed, and made ready for a good night's sleep. She stated she had some pain on coughing, but was resting quite comfortably with two pillows beneath her head to ease dyspnea.

By the next morning Mary's temperature had returned to 98° and she felt much improved. A sputum specimen was sent to the laboratory. She had a complete bedbath though she washed her own face and hands. She gave one of the nurses money to buy a toothbrush and toothpaste at the Canteen.

Her frequent dry harsh cough still bothered her, but she had stopped perspiring. She was thirsty, and took fluids very well, finishing a quart of tomato juice (which she preferred) in just over an hour. Continuous steam was running at her bedside into the steam tent. Cheerful when awake, she slept long periods most of the day. Her appetite was poor. She took only light custard and fluids from her meal tray. Deep breathing and coughing were encouraged each morning during her bedbath.

That evening her temperature rose to 101.8°. Extra blankets remained

on her bed. She was coughing less frequently and had less chest pain.

The next day she had another chest x-ray for the purpose of defining the progress of the area of pneumonitis found previously. She was transported by wheelchair well wrapped in blankets. The report stated: "The area of density in the base of the right lung appears unchanged." Her chest pain had disappeared, her cough was infrequent, her production of sputum was scant, but she appeared weak and lethargic, sleeping much of the time.

Continuing to feel better, after being allowed to dangle, she got up in a wheelchair on the third day. She was surprised at being so weak while up but began to feel restless and bored while in bed. She continued to drink large quantities of fluids and have steam running into her steam tent. Bathroom privileges were granted.

Slowly her appetite improved until she progressed to a full diet. Staying up longer each day, she soon was anxious to go outside. Since she was missing school, her textbooks were brought to her and she concentrated on homework. She mixed well with other younger patients and one evening joined them at a show in the hospital auditorium.

Mary's elimination was watched closely. While taking fluids only, she did not have a bowel movement, but upon progressing to a soft and later a full diet her bowels moved regularly. Even though she was up most of each day, she frequently took an afternoon nap.

A chest x-ray done on the eighth day revealed that the rounded area of density had diminished in size and density. Laboratory work was repeated with the following results: the hematocrit rose to 37%, showing an improvement in her general condition; the sedimentation rate dropped to 44. Her temperature remained at 98.6°.

Complications for which we as nurses should be on the alert with any patient having pneumonia:

1. Septicemia; bacterial invasion of the blood stream was a possible complication of Mary's pneumonia, and was combatted by large doses of penicillin.
2. Meningitis, purulent arthritis, acute sinusitis, peritonitis, acute otitis media, or acute bacterial endocarditis may result from pneumococcal infection invading the tissues from the septicemia.
3. Atelectasis, collapse of the lung, is caused by the obstruction of a bronchus with accumulated secretions.

The Future

Mary's foster parents accused her of sneaking out late at night and being rebellious, which she denied. They refused to allow her to return. She cried and did not want to leave hospital until her social worker reassured her by taking her to a new foster home.

Since she has come under the Department of Child Welfare she has been given sufficient essential clothing; previously she did not even own a winter coat. If she became established in a good foster home, she stated, she would like to know others in the community and earn money baby-sitting.

Being in grade nine, she had to write departmental examinations, which was the reason for her being so upset about changing foster homes. However, her new home was within bus distance of the same school. She was concerned about her schooling, and worked with her textbooks frequently during her stay in hospital. Her school principal showed interest in her and she highly respected him. She has planned for several years to finish high school and enter nursing.

Of her own choice, she had joined a church less than two months before entering hospital. She was a member of the choir, and enjoyed a visit with her minister during her stay. She said that she was getting religious training for the first time in her life.

Mary recovered from her pneumonia with no after-effects. Her prognosis is excellent, but she should be careful to avoid contact with people having upper respiratory infections, not to become chilled or fatigued, to obtain sufficient rest every night, to take an adequate diet including foods that are rich in iron.

What I learned

While caring for Mary Duval I came to realize the importance of understanding the factors pertinent to recovery. Her social misfortune, economic needs, and spiritual want all were contributory to her condition. A realization of the nursing care involved

and a clearer understanding of upper respiratory infections was mine after caring for her; also how vital health teaching is since Mary's pneumonia could be directly traced to lack of proper care.

Her minister, principal, social worker, guardian (the latter two appointed by the Department of Public Welfare, Provincial Government) and others she has met through the hospital must give her love and security which she so desperately needs. She is dependent on these friends to help fill a little of the gap caused by lack of a proper home.

Spina Bifida and Hydrocephalus

SHIRLEY PERRET

SPINA bifida is the simplest of the spinal malformations that may be present at birth. It results from the incomplete fusion of the bony arches of one or more vertebrae. The protusion of meninges through a spina bifida, a meningocele, may occur. Even more serious is the condition known as myelomeningocele when the spinal cord elements protrude into the sac of the meningocele.

Medical science has not been able to explain why these developmental defects of the spine occur. The lumbosacral region is the most frequent area involved though a spina bifida occasionally is seen in the upper cervical region. Involvement in the thoracic region occurs very rarely. The area involved in the incomplete fusion may be so small as to appear simply as a dimple in the skin. An x-ray is taken to verify that it is due to defective bone structure. When a meningocele is present there is an external bulge of a sac covered by a thin layer of skin, sometimes cyanotic, containing cerebrospinal fluid. This sac is translucent. When other spinal elements are extruded into the sac, it does not transilluminate clearly.

The protective skin of the meningocele may be extremely thin so care must be taken constantly to avoid irritation. Rupture of this sac with leakage of cerebrospinal fluid and consequent risk of infection must be guarded against at all times. Meningitis may follow the rupture or infection of the sac.

Closely associated with this abnormality is possible alteration in the shape and size of the head. Its circumference should be recorded in centimeters each morning. The fontanelles should be examined at least three times each day and any signs of tension or bulging reported immediately.

An infant with a lumbosacral meningocele should be placed on the abdomen with the head turned to the side. The hips and pelvis should be elevated to prevent possible contamination of the sac by urine or feces. Sandbags are placed on either side of the baby to prevent it from rolling over. A small cradle should be used to support the weight of the bedclothes. The use of cotton doughnuts over the sac should be avoided as they may cause friction. If some protection of the immediate area is required, as for example when it is necessary to transport the baby for any distance, a wire strainer of suitable size may be used.

Baby Jean

A twenty-five-year-old multipara was admitted to hospital in labor, two weeks after the expected date of her confinement. After a long and difficult delivery, she gave birth to a seven and three-quarter pound daughter. The baby's cry was loud, her color good and her temperature normal.

An abnormality diagnosed as spina bifida was apparent in the lumbar region. There was a "jelly-like mass" beneath the surface of the skin from which a slight serous discharge was oozing. Hydrocephalus was evident in the bullet-shaped head.

Miss Perret is a graduate of Holy Family School of Nursing, Prince Albert, Saskatchewan.

The baby was admitted to the nursery where careful posturing was done to avoid pressure and irritation on the meningocele. A cow's milk formula was prescribed which she took fairly well. The mother was in great distress emotionally each time the baby was brought to her. The nurse was able to persuade the mother to overcome her fear of holding the infant.

By the second day it was observed that the meningocele was enlarging. The temperature was elevated to 102.2°F. Normal saline, 50 cc., was given interstitially and Achromycin, 10 drops every eight hours, was started. The next day the baby's bowels began moving almost continuously, the loose stools showing traces of serosanguinous discharge. It was noted that the rectum had prolapsed. Examination by a neurologist revealed that the baby was an incurable hydrocephalic.

Neosporin ointment and a dry sterile dressing was applied to the protruding meningocele. It was observed that her breast were engorged and quite hard.

Baby Jean fussed considerably during feedings but took her formula with persuasion. Pablum feedings were started and she made good attempts at eating.

By the time she was three weeks old the baby's head was becoming noticeably enlarged. There was abnormal bulging of the frontal bone. The eyes were sunken with a staring downward glance.

At six weeks of age the circumference of the baby's head had increased by another inch. She was regurgitating most of her feedings so she was fed by gavage. She became very cyanosed with shallow, wheezy respirations. Mucus in her throat became troublesome. When it was suctioned out, it was noted that the mucus was blood-tinged indicating the presence of bronchopneumonia. Oxygen was started but the baby did not respond.

Postmortem examination revealed that the fontanelles were widely open, the brain tightly compressed against the overlying dura. There was a purulent exudate obstructing the Aqueduct of Sylvius which produced the internal hydrocephalus.

What I learned

It was apparent from birth that this congenital abnormality could not be cared for in the same way as a normal infant. It needed frequent extra care and attention, especially to prevent infection of the protruding meningocele. Special care to the buttocks was also important.

Though the parents knew that the baby was not going to live they wanted to be reassured constantly that everything possible was being done for their baby. The mother was very apprehensive regarding the possible malformation of any children she might have subsequently. She was made to understand that it was very unlikely that there would be an other abnormality in later pregnancies.

A new chemical preparation that softens impacted ear wax so that it may be easily removed is now available.

The standard method for removing ear wax is to irrigate the ear and then remove the wax with a blunt instrument. If the wax has been impacted for a long time, the outer layer of the ear canal skin may become attached to the wax. When the wax is removed, the skin is torn. A wax-dissolving substance will prevent such injury to the skin.

The new preparation, with the tradenames Cerumenex and Cerulau, is put into the ear a day or two before the wax is removed. By that time, the wax is soft, loose and easy to remove.

The preparation was used on 230 patients with varying degrees of excessive and impacted wax. A "dramatic" wax dissolution was observed in most instances, with complete removal in 204 patients (88.7 per cent). Nineteen (8.2 per cent) had good results and seven (3 per cent) poor results. No patient showed an adverse reaction to the agent.

— *The Health Bulletin,* North Carolina State Board of Health.

* * *

I love the Christmas-tide, and yet,
I notice this, each year I live,
I always like the gifts I get,
But how I love the gifts I give.

— Carolyn Wells

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Season's Greetings

The staff of National Office join hands in wishing all members of the Canadian Nurses' Association a happy and joyful holiday season. A Merry Christmas to one and all.

Chairman Resigns

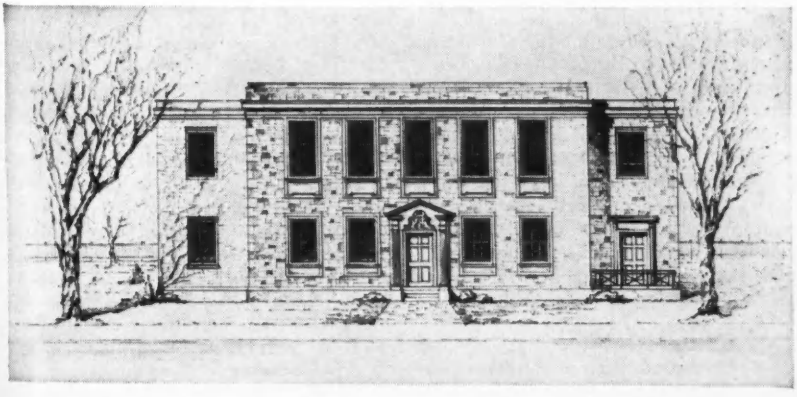
MRS. OGDEN MARTIN, who has been chairman of the National Office Auxiliary since its organization in 1954, has found it necessary to resign. We are pleased, however, that Mrs. Martin has consented to continue as a member. We record grateful appreciation for the contribution which she has made to our Auxiliary during its organizational period.

The National Office Auxiliary, for those who may have forgotten, is a group of volunteer nurses in the Ottawa area, who assist with the entertainment of international visitors, cataloguing of Archives and proofreading of manuscripts which, incidentally, is a sizeable task in National Office. Beside these duties the Auxiliary, as a means of raising money for the CNA House Fund, has served refreshments following meetings of the local chapter of the RNAO. This fund now stands at $2000.

From staff to volunteer — our Rita MacIsaac, now Mrs. E. J. EGAN, after five years as a valued member of National Office staff returns to the CNA program as chairman of our National Office Auxiliary. Mrs. Egan knows the functions of the Auxiliary exceedingly well having worked closely with the chairman in every detail of the program. We welcome this continued association with our former colleague.

We've Moved

As you read these notes the staff of National Office will be busily engaged in settling into their new offices, located on the second floor of



New CNA Offices are at the Royal College of Physicians and Surgeons of Canada.

the new home for the Royal College of Physicians and Surgeons. A description of this spacious and attractive building was included in this column in September.

It would be an understatement to say that we are delighted with our new surroundings. These bright, new, quiet offices are conveniently located at **74 Stanley Avenue** on the Bank of the Rideau River, about ten minutes by bus from the Chateau Laurier Hotel.

May we issue to all members of the Canadian Nurses' Association a most cordial invitation to visit your new National Office when you come to Ottawa. We will be delighted to welcome you.

Canadian Council on Nutrition

One of the privileges of your National Office staff is to represent the Canadian Nurses' Association at important meetings. The 25th annual meeting of the Canadian Council on Nutrition, of which the general secretary is a member, met in Ottawa last September.

Besides experts in nutrition research the Canadian Council has representation from Canadian Home Economics Association, Canadian Dietetic Association, Canadian Teachers' Federation, Canadian Medical Association as well as the Canadian Nurses' Association. It is an advisory group to the Department of National Health and Welfare.

Nurses Invited to Nutrition Course

The Canadian Home Economics Association is holding its biennial convention in Edmonton, July, 1960. A three-day course on nutrition is being organized to precede the convention. Through the CNA, nurses are invited to attend this course. This is an opportunity for members of the nursing profession to join with nutrition experts' teachers and representatives of other disciplines in the study of newer trends in nutrition. More detailed information will appear in this column later.

CNA Committee Meetings

As the second year of the biennium speeds along your national committees are continuing the activities to which they pledged themselves in 1958. The following is an indication of what is planned in the way of meetings:

Committee on Nursing Education — November 26, 27.

Curriculum Workshop — to be held in conjunction with the meeting of the Committee on Nursing Education — November 23, 24, 25.

Committee on Nursing Service — November 12, 13, 14.

National Committees on Finance, Legislation and By-Laws, and Public Relations will also be meeting before the new year.

Previous issues of Nursing Across the Nation have indicated the projects undertaken by these committees. Watch this column for further information concerning committee activities.

The 30th Biennial Meeting

Convention Program

Careful consideration is being given to the program of the 30th Biennial Meeting of the CNA to be held in Halifax June 19-24, 1960. Regardless of your field of nursing there will be much to interest you. In the general sessions nursing topics which concern all of us will be discussed.

In outlining the program your committee, under the chairmanship of **Elizabeth Reed,** is bearing in mind the convention theme "Faith" and the fact that 1960 is World Mental Health Year. The initial draft of the program for this meeting is included in this issue.

Prospective Post-convention Tours

Plan now for your vacation following the Biennial Meeting. Tentative plans are in progress for several interesting short tours in the Maritime provinces — from one to ten days in length—by boat, plane, bus or train. These historic Atlantic provinces have a unique charm and beauty, with many special places of interest, that are well worth enjoying.

A preview of the tours which are now in the planning stage, is introduced here for your consideration. Final plans and costs, which are dependent on the number of nurses who wish to participate, will appear later in *The Canadian Nurse.*

Nova Scotia with its ever-changing beauty and hospitable people offers you

Preliminary Program

Watchword -- "Faith"

Sunday, June 19th

Registration

Evening Church Services:

St. Paul's Cathedral (P)

St. Mary's Cathedral (RC)

Monday, June 20th

Invocation

Official Opening: Keynote Address

Presidential Address

Finance Committee Report

General Secretary-Treasurer reports on CNA activities including CNA Retirement Plan

Special Student Session

Garden Party

Halifax Public Gardens
5:00 - 7:00 p.m.

Tuesday, June 21st

Pilot Project —

Report of the Director

Report of the Special Committee

General Discussion —

Is it desirable to initiate a program of accreditation? Upon your judgment rests the future course of nursing in Canada.

Special Luncheons with Speakers

Special interest group discussions

Evening will be devoted to Special

Speaker and summary of group discussions

Wednesday, June 22nd

Panel Presentation dealing with the patient's return to the community

Free Afternoon

Cruise on the Harbor followed by a Lobster Supper at *H.M.C.S. Stadacona*

Thursday, June 23rd

"President's Conference"

Presentation of Committee Reports

Special Speaker to be announced

Panel Discussion

President's Reception —

For CNA members and special guests

Music and Entertainment

Friday, June 24th

Voting on Resolutions

Report of Scrutineers

Editors' Conference —

"Communications in the Health Field"

Address related to theme "FAITH"

Conferring of Honorary Memberships

Installation of Officers

Closing Reception — Nova Scotian Hotel guests of R.N.A.N.S.

MAKE PLANS NOW TO ATTEND AND TAKE AN ACTIVE PART IN THE WELFARE AND FUTURE OF CANADIAN NURSING

a tremendous vacation with a variety of interests. The Acadian Bus Lines have five different tours that cover interesting areas. On Cape Breton Island, the Cabot Trail and the Keltic Lodge invite you to a week of relaxation and fun. Canada's ocean playground can also be seen by motorcar with a special guide who will assist passengers to select the most interesting route.

New Brunswick's natural wonders and mementoes of early Canadian History; Prince Edward Island, the red and green vacation fairyland; Newfoundland, Britain's oldest colony and Canada's youngest province, which has a rugged beauty of its own all warmly invite you to pay a visit.

The excitement of New York's Broadway, the interesting tours to the United Nations, Greenwich Village, and the Bowery can be yours for six days by boat or plane. There is also a possibility of a short sojourn in Bermuda, that island of beauty, where there are many fascinating sights and activities.

We have been advised by the Halifax Tourist Bureau that local tours will be available during convention week. If you are touring in personal cars, guide material may be requested for easy and selective planning.

An expression of your interest in any one or more of these tours will be welcomed. For further information write to:—

The Canadian Nurses' Association,
74 Stanley Avenue,
Ottawa, Ontario.

The CNA Resarch Committee

The committee held its first meeting in Ottawa last September. It proposed to set up working parties to prepare a statement of:

1. The philosophy (or theories) of nursing and its role in contemporary society. This statement will be submitted to the CNA Executive Committee for acceptance as CNA philosophy.
2. The functions of nursing personnel and the probable changes that will take place in the foreseeable future. This statement is to include all categories of nursing personnel in all fields of nursing and will clearly define the terminology of nursing categories.

The Committee feels that these statements are necessary preliminary steps to further studies of nursing service. They also discussed the need for summaries of reports of Canadian studies in nursing already undertaken. Two types of summaries of a selected Canadian study are to be prepared for the consideration of the Committee members. A decision will then be made as to the type of summary most useful to Canadian nurses.

Ideal Retirement Plan for Nurses

Ideal for the nurse who wishes to provide for herself security in retirement conveniently, with high earnings, income tax deductions and a pension in the dollars of the day.

Ideal Features

- — Especially designed for nurses.
- — Deposits where and when convenient (monthly, annually) at your closest Bank of Montreal.
- — Amount of deposit adjustable to nurses' circumstances.
- — High interest rates and dividends with bank security.
- — Choice of type of pension at retirement.
- — Pension rates highest possible for your accumulated dollars.
- — Contributions deductible for income tax purposes.

Underwriters of the plan are specialists in fields of pensions and investments:

The Royal Trust Company — foremost investment experts in Canada.

The National Life Assurance company of Canada — specialists in group pension coverages.

The Bank of Montreal — branches coast to coast where deposits can be made.

The usual plans available to you as an individual can offer only a very few of these desirable features. *Only your Canadian Nurses' Association Retirement Plan can give you all of them.*

JOIN NOW BY SIGNING THE APPLICATION ON THE NEXT PAGE AND RETURN IT TO THE CANADIAN NURSES' ASSOCIATION, 74 STANLEY AVENUE, OTTAWA, ONTARIO. You do not have to make any contributions immediately. This sets up the facilities to permit you to take advantage of this exceptional plan — *with the added privilege of tax relief from your 1959 contributions.*

Application for Participation in the

CANADIAN NURSES' ASSOCIATION RETIREMENT PLAN
REGISTERED RETIREMENT SAVINGS PLAN SECTION

I hereby apply for participation in the Canadian Nurses' Association Retirement Plan, the provisions of which are familiar to me. I understand that such participation entitles me to membership in certain Retirement Savings Plans, arranged with The National Life Assurance Company of Canada and the Royal Trust Company, and my application for such membership is indicated by my request that contributions be allocated to such Plan or Plans. I request that the instruments evidencing the terms of such membership be registered as Retirement Savings Plans under the Income Tax Act (Canada). I understand that as a consequence of such registration payments out of the Plans can only be made in the form of a life-contingency annuity or a death benefit and that such payments to me or to my beneficiaries, executors or legal representatives will be subject to tax under the provisions of the Income Tax Act of Canada.

I understand that I am required to make payments into C.N.A.R.P. on a regular basis of at least $100 yearly, and that the first $100 of contributions in each contribution year will be directed to the Insured Annuity Retirement Savings Plan, underwritten by The National Life Assurance Company of Canada. In respect of contributions in excess of $100 in any contribution year, I request that [ ] percent of these future excess contributions be apportioned to my account in the Insured Annuity Retirement Savings Plan, underwritten by The National Life Assurance Company of Canada, and that the remainder of such future excess contributions be apportioned to the Common Stock Retirement Savings Plan, managed by the Royal Trust Company, and be commingled therein with the payments made by other members. I understand that this percentage allocation may subsequently be varied by written notice in accordance with the provisions of C.N.A.R.P.

I undertake, upon request, to provide proof of age satisfactory to the issuer in respect of any annuity contracts provided to me as a benefit under these Plans.

I hereby appoint The Canadian Nurses' Association to act as my Agent in the negotiation of contracts and agreements to carry out the provisions of C.N.A.R.P. and through the Association, I grant discretionary investment power to the managers of the Common Stock Retirement Savings Plans.

DATE ..... SIGNATURE .....

WITNESS .....

PLEASE PRINT OR TYPE REQUIRED INFORMATION

NAME ..... CERT. No. .....
SURNAME COMPLETE CHRISTIAN NAMES

ADDRESS .....
STREET AND No. CITY OR TOWN PROVINCE

DATE OF BIRTH ..... SEX ..... MARITAL STATUS .....
DAY MONTH YEAR

CONTRIBUTIONS — ☐ Regular payments through your local branch of the Bank of Montreal .....
BRANCH CITY OR TOWN

Check (V) method of payment ☐ Payment to the Bank of Montreal of certain regular amounts to be charged to your account in a branch of another bank.

.....
NAME OF YOUR BANK BRANCH CITY OR TOWN

Each contribution year ends on the ninth day of the month of February. All contributions made during each yearly period — February 10th to February 9th — are classified for tax purposes as contributions made during the calendar year which ends during this specific period. Thus, contributions made prior to the ninth day of February, 1960 are considered to be 1959 contributions. In order to so qualify, your contributions must be deposited in a branch of the Bank of Montreal on or prior to February 9th, 1960.

Each contribution will be acknowledged by the Bank of Montreal by an entry in a special pass-book. Each year you will receive a statement of accumulated contributions and a certificate for income tax purposes.

DEATH BENEFITS —

Benefits payable after your death will be paid to your executors or legal representatives. You may, however, indicate below the name of a beneficiary to receive that portion of any such benefits which arises out of your participation in the Insured Annuity Retirement Savings Plan.

BENEFICIARY'S NAME .....
SURNAME CHRISTIAN NAMES

ADDRESS .....
STREET AND No. CITY OR TOWN PROVINCE

RELATIONSHIP TO YOU .....

DATE ..... YOUR SIGNATURE .....

WITNESS .....

CANADIAN NURSES' ASSOCIATION
74 STANLEY AVENUE, OTTAWA, ONT.

Mental Effects of Head Injury

JOHN GIBSON, M.B., Ch.B., D.P.M.

TWO WORLD WARS and the high incidence of road accidents have brought into prominence the mental effects of injuries to the head. In severe injuries the brain substance may be torn, hemorrhages may occur in it or in the extradural space, cerebral edema may follow, and nerve fibres may eventually become demyelinated. The nature of the change that produces instant concussion of slight degree is unknown.

Concussion may be slight, moderate or severe. In slight concussion, unconsciousness may last from a few seconds to a few hours, or there may be only incomplete loss of consciousness. On coming round the patient may pass through a short stage of confusion and have a headache and drowsiness. He has a loss of memory for the injury and for a short period after it. In moderate concussion he is unconscious for several hours; emergence is a slow process, and for some hours or days he may show some clouding of consciousness with irrational thought processes, disorientation in time and place, misidentification of people and misinterpretation of events. He may develop an acute delirious state with delusions, hallucinations, excitement and violence, after which he may pass into a dull and apathetic state and show gross loss of memory. In severe concussion the patient may be unconscious for several days, be severely shocked and die. In those who do not die, acute delirium and prolonged clouding of consciouness are likely.

During convalescence after any degree of concussion the patient may have headaches, be slightly confused at times, and have an amnesia for the injury and for a time after it. The post-traumatic amnesia is the time from the injury until the time when the patient becomes continuously aware of his surroundings. It has been shown that the length of this time is a measure of both the severity of the concussion and the length of time the patient will be off work. A patient with a post-traumatic amnesia of under one hour usually returns to work within four to six weeks, one with an amnesia of from one to 24 hours within six to eight weeks. The EEG is made abnormal by the injury, and the worse the injury the longer the EEG remains abnormal, except in those patients whose brain cells have been extensively destroyed and are therefore unable to produce electrical discharges.

The postconcussional syndrome is a common condition and one liable to become in some degree chronic. It is more common among neurotics, people with a neurotic predisposition, and people with a family liability to develop neurotic patterns of behavior. Symptoms are numerous and include: chronic headache, giddiness, anxiety, difficulty in concentrating, blackouts, insomnia, fluctuating moods, irritability, hypochondriasis, fatigue and a characteristic inability both to work and to play. It is more common in industrial accidents than in accidents received in sport, and a prospect of receiving compensation for the injury is a factor in maintaining the condition.

Post-traumatic epilepsy occurs in about 2-4 per cent of head injuries. Convulsions usually appear within two years of the injury, but may appear much later. Those occurring within the first few days usually stop spontaneously, and the longer the interval between the injury and the first convulsion the more likely they are to persist. Grand mal attacks are the most common variety, but other forms may occur. The treatment is as for idiopathic epilepsy.

Post-traumatic dementia is liable to occur especially in patients who have been seriously injured, been severely concussed, and had a prolonged delirium; and in old people and arteriosclerotics. Typical symptoms are a progressive loss of memory, retardation, inability to concentrate, poor

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the fourth of a series of articles on psychiatric subjects.

association, poverty of ideas, and reduction in reasoning power. Degenerative changes in the prefontal lobes are particularly liable to produce explosive mood changes, lack of control, irritability, and outbursts of violence.

Punch-drunkenness is a post-traumatic dementia produced in boxers by repeated blows to the head and by hitting the head on the floor of the ring. Typical features are: loss of memory, decline in intelligence, retardation, dullness, fatuousness, ataxia, tremor of the arms, and slurred speech.

Chronic subdural hematoma is due to bleeding into the subdural space. The bleeding may be slow and symptoms may not appear for several weeks or months. A trivial injury, such as knocking one's head in getting into a car, may be sufficient to produce the bleeding. The symptoms are: headache, drowsiness, apathy or excitement, confusion and convulsions. Typically, the symptoms vary very much from day to day, the patient appearing seriously ill one day and much better the next. Treatment is by surgical removal of the hematoma.

Psychoses of the schizophrenic, paranoid or manic-depressive kind may occasionally follow head injury, but rarely if ever can it be attributed to it. Almost all affected in this way have had previous psychotic attacks or have shown a definitely abnormal personality of the appropriate prepsychotic variety before receiving the injury. Treatment is that appropriate to the psychosis.

Psychiatric treatment should be begun as soon as the patient recovers consciousness. In addition to his uncertain hold on consciousness and his confusion and headache, he will be bewildered by what has happened. He should be told simply. It may be necessary to repeat this information many times over several hours or days. From the very first he must be surrounded by positive optimism, be reassured of recovery, and possible symptoms must not be mentioned to him.

As soon as possible he should get out of bed, and engage in exercises, games, occupational therapy, and work designed to give him reassurance and to promote a return of his former skills. The treatment of an acute neurosis may be necessary. Patients with special disabilities may require re-education and training. A quick payment of any compensation and the resumption of work are of importance in the prevention of a postconcussional syndrome.

Relieving Pressure on Acute Wards

Patients who come into hospital for diagnosis or who are having long but not incapacitating treatment from a department in the hospital, may not need full admission to a hospital and could be happier in an annex or hostel environment.

Convalescent patients, too, are now found alongside the acutely ill, although their needs are quite different. Provision of "recovery" beds attached to outpatient departments for those whose treatment can be completed in a few hours would free more beds for the acutely ill.

Sunday Times, London

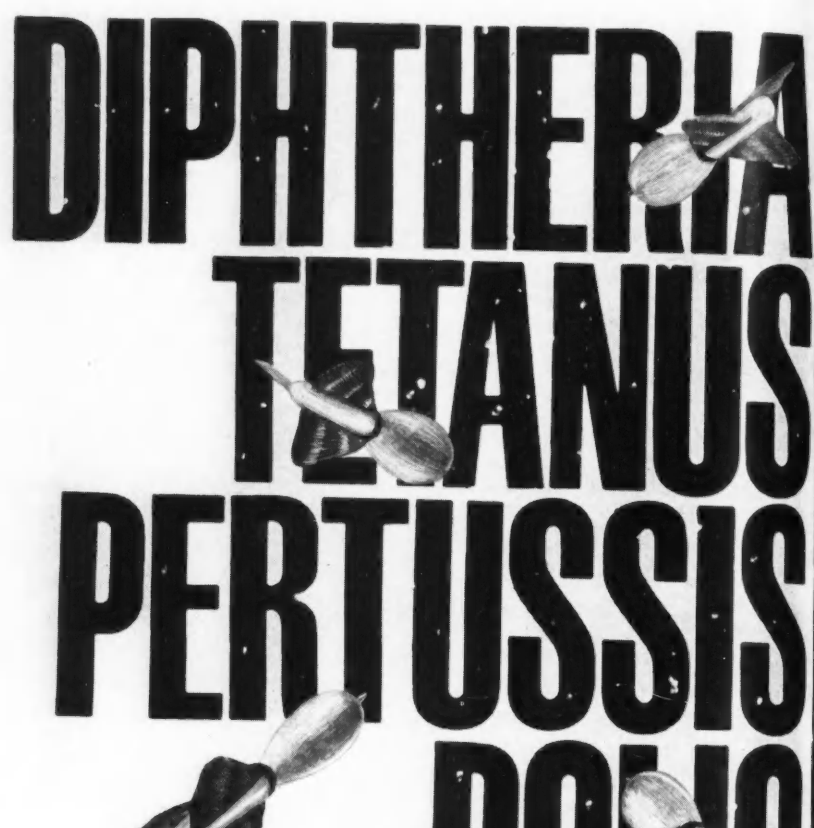
* * *

Between the ages of one and three, children frequently turn from "eager eaters" to "negligent nibblers."

During the first year of life, babies usually triple their birth weight; during the second year, a gain of about five pounds is average. Moreover, this relatively small weight gain, as compared to the first year, is never steady. For two or even three months at a time the weight may be stationary. During these lulls in growth, the appetite wanes and not only does the child need little food, he wants little. In addition, the youngster has reached the "negative stage," in which he is developing a will of his own.

In most cases, children will select what they need and want if left alone over a period of time. However, the mother must still provide the opportunity for the eating of a balanced diet. If the mother will watch the trend of the child's appetite and serve his plate accordingly, it will cut down on waste and spare her nerves.

Today's Health, American Medical Association.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*Barrett, C. D., Jr., *et al.*: *J.A.M.A.* 167:1103, 1958; *Ibid.*: Am. J. Pub. Health 49:644, 1959.

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Hurler's Disease

MARILYN PHILIPPE

DAVID aged five, was the youngest member of a family of five children. Accompanied by his parents, he was admitted to the pediatric department of the hospital for diagnosis and treatment. At first he was frightened in his new surroundings and cried almost continuously. However, a few minutes spent in the arms of a friendly nurse who carried him about the ward showing him the pictures, the toys, the aquarium and the other children, helped him to settle down quietly with his own play things.

Medical History

The history received from the parents indicated that David had had difficulty in breathing and had been brought to hospital for a general check-up. Previous records showed that he had been admitted at the age of four months for treatment of acute bronchitis with nausea and vomiting. When David was five months old he was admitted again with bronchopneumonia and at seven months of age, he had a severe upper respiratory infection.

On examination shortly after this admission it was found that he had definite bilateral corneal opacities and a small umbilical hernia. His abdomen and liver were enlarged and a mass was felt in the left hypochrondrium. There were obvious skeletal deformities, e.g. a short neck and the anterior and posterior diameter of the chest appeared greater than normal. The tentative diagnosis was gargoylism.

Signs and Symptoms

David had the typical signs of gargoylism. He had dyspnea on little exertion and profuse nasal discharge at all times. His chest was greatly expanded with kyphosis in the dorsolumbar region. He walked with a peculiar gait. His head was malformed and his cheeks were pouched. His neck was short and his tongue was slightly enlarged. His abdomen was enlarged, and a small umbilical hernia was easily recognized. The joints of his fingers showed limited extensibility, the breadth being greater than the length. The fingers were maintained in a clawing position. David did not speak plainly either. His mother believed that he was mentally retarded. It was her wish that he would be sent to an institution for such children.

David did not show severe mental retardation. He was alert and bright with a good memory. One afternoon as I colored pictures with him I was pleased to observe that he had learned to know the colors of the crayons. He could point out pictures in a book and name them. Only his speech and size were indicative of retardation. He was a very lovable child and a favorite with all of the staff. He seemed to crave affection. He could play easily with the other children and he showed no shyness with anyone.

His temperature, pulse and respiration were normal when he was admitted and remained so throughout his stay in hospital.

Laboratory Results

Blood and urine studies were essentially normal.

The diagnosis as confirmed was gargoylism, also called Hurler's Syndrome, dysostosis multiplex or lipochondrodystrophy.

Definition

This disorder is the result of metabolic disturbance that affects the skeletal structure as well as the soft tissues. Although the metabolic disturbance is present at birth the symptoms develop only in postnatal life. The disease exhibits cloudy corneas, hepatosplenogaly, mental deficiency, skeletal changes and dwarfism. Either sex may be affected. The disorder is genetically determined. Most cases are due to a single recessive gene. Sex-linked recessive transmission has also been observed.

The basic metabolic disturbance results in the accumulation of an abnor-

Miss Philippe is a graduate of St. Joseph's school of nursing, Hotel Dieu Hospital, Kingston.

mal extra cellular material that affects the cells and the structure of many organs. The nature of the stored substance has not been determined. It is considered a lipid by some and a mucoproteid by others.

Clinical Manifestations

The skull is frequently malformed and may be scaphocephalic, oxycephalic or hydrocephalic. The closure of the anterior fontanel may be delayed. The supraorbital ridges are prominent, and the bridge of the nose is depressed. A profuse nasal discharge is usually present. The tongue is enlarged and the neck is short. The heart is frequently enlarged and a systolic murmur can be heard. Dyspnea is noticed on slight exertion and cyanosis occurs in advanced stages. The liver and spleen are enlarged. Externally, the sex organs appear normal but in the female maturation does not occur.

The combination of the claw-like hands, the large head, the grotesque facies and deformed limbs accounts for the designation of "gargoylism." The thickness of the head contributes to the characteristic picture. Corneal opacities and mental retardation occur in a large percentage of these children. In the white blood cells abnormal granulations. *Reilly bodies,* may be found, but laboratory studies show no other characteristic changes.

The stunted growth, the thickness of the skin and mental retardation suggest cretinism, but the splenomegaly and roentgenographic changes are adequate for differentiation. Roentgenograms show the sella turcica to be elongated in many cases. The changes of the spinal column are best seen in the lateral view. The vertebral bodies are shortened in the sagittal directions, their anterior and posterior outlines appear concave and the spinous processes are directed downward. The first or second lumbar vertebra is smaller and displaced backward, resulting in a marked deformity of the spine. The lower ribs are club-shaped. The humerus is long and thick. The ulna and radius are short and thick. Their epiphyseal ends and their epiphyses have irregular outlines. The metacarpal bones are bottle-shaped, the basal phalanges cylindrical. The femur, tibia, fibula are moderately thickened and their epiphyses are angular.

The disproportionate shortness of the extremities of classical chondrodystrophia is absent in gargoylism. The deformities of the head, the appearance of the hands, and the mental retardation distinguish gargoylism from Morquio's disease or eccentro-osteochondrodysplasia.

The prognosis is unfavorable. The patient remains retarded in mental and physical development. Orthopedic treatment helps to correct the deformity of the spine.

Diet

David had a fairly good appetite and was able to feed himself. He liked milk especially well. He was on a regular diet for his age.

Nursing Care

David's skin was very dry. Quite frequently he was rubbed with baby oil and this helped a great deal. He required constant nasal care due to the profuse discharge.

The main problem encountered in caring for David was his homesickness. His parents never came to visit him. He made friends with the parents of a little girl in the next room and usually became upset when it was time for them to leave. He could always be persuaded to go to his bed if someone read a story to him. He would settle down quietly and once the light was turned off, would go to sleep.

David usually amused himself by playing with a large boxful of toys. Quite often we could hear him singing happily to himself.

Medication

The only medication that David received was thyroid tablets one grain daily. It was thought that this might help him if he had a deficiency of thyroid gland secretion.

Patient Teaching

1. Personal hygiene — David was taught to place his hand over his mouth while coughing and to blow his nose. We showed him how to brush his teeth and attempted to teach him to comb his hair — sometimes he did very well. He learned to wash his own face and hands; to use toilet tissue; to dress himself.

2. We tried to help him speak more plainly but we did not succeed too

well although at times he could say certain words very clearly.

3. He learned to color pictures neatly and to recognize the different colors of the crayons.

4. We taught him to eat with a fork instead of his fingers.

5. We made him realize that after lunch he and all the other children had to have an afternoon sleep. At first this did not please him too well but after a few days when his dinner tray was taken away he went to the bathroom, came back to his bed and asked for his blanket. It was not long before he was fast asleep.

Summary

When he was ready for discharge from hospital David's father came to bring him home. He said that they had not decided definitely about sending the boy to an institution.

David needs loving and may not live beyond the age of seven. He presented no problem in care to the nurses. It would seem preferable if his parents, in full realization of his poor prognosis, would be willing to give him the love and attention that he craves, for the short time he has to live.

We tried to impress on his father that David needed a great deal of love and attention. Apart from this, dietary and medication orders were the same as they had been in hospital.

Glossary

chondrodystrophia — a defect in the formation of bone from cartilage, congenital in origin.

dysostosis — defective formation of bone.

lipochondrodystrophy — a congenital disease characterized by dwarfism with a short, kyphotic spinal column, short fingers, etc.; another name for gargoylism.

Morquoi's disease — a type of imperfect ossification due to eccentric centers of ossification in which the bones of the extremities fail to develop normally and become rarefied and deformed.

oxycephalic — a conelike appearance of the head.

scaphocephaly — a projecting, keellike sagittal structure of the skull due to premature ossification.

Hospital Sepsis: A Communicable Disease

We were privileged to be present at the Canadian première of a half-hour color film "Hospital Sepsis: a Communicable Disease" that was shown at the World Medical Association convention in Montreal in September, 1959. This is a documentary film that was produced to help educate hospital personnel concerning the spread and control of infection. The film begins with a series of pictures of patients in the 18th century. It depicts the first awareness on the part of doctors of the problem of the spread of infection. The same problem exists in our modern institutions 200 years later, in spite of our increased understanding of microbiology.

The documentary portions of the film trace the hospitalization of a patient with a ten-year history of carbuncles and boils, from the time of her admission to a private, germ-free room. Subsequent scenes reveal that the organisms can be located in every corner of the institution, having travelled via personnel, the air-conditioning system, stairways, laundry chutes, cleaning apparatus and a multitude of other carriers and growth media. The film frightens the viewer, but methods of control and prevention are possible if we understand the complexity of the problem and are willing to take the necessary action. The film cannot be too highly recommended for viewing by all categories of hospital employees.

Sponsored jointly by the American Medical Association, the American College of Surgeons and the American Hospital Association, and made possible through a grant from Johnson and Johnson, this film is available on request.

A discussion manual supplementing the film is now available to hospital administrators. This 44 page manual, contains 39 questions and answers, 29 illustrations, charts and pictures, and is in color.

Write to: **Johnson and Johnson, 2155 Pie IX Blvd., Montreal.**

Nursing Profiles

The Vancouver branch of the Victorian Order of Nurses has a new district director in the capable person of **Christine E. Charter.** Miss Charter took over the responsibilities of this position during this past summer following the retirement of Miss Alberta Creasor. She had been the assistant director of this branch since 1944.

(Campbell)

CHRISTINE E. CHARTER

Born in England, Miss Charter came to Canada at an early age. She is a graduate of Saint John General Hospital, N.B., holds her certificate in public health nursing from the University of Toronto, and a Bachelor of Science degree from Columbia University. Her experience with the V.O.N. began in Eastern Canada with her appointment as a staff member of the Halifax unit. Later she spent several years as nurse-in-charge of the Liverpool, N.S. branch before going on to a supervisory post with the Toronto branch. In 1944 she joined the Vancouver unit.

Apart from her interest in professional matters, the new director has a variety of favorite leisure-time activities. Weaving, music and reading occupy quieter moments with Scottish country dancing as an outlet for suppressed energy. We take great p'easure in extending warmest congratulations and best wishes to Miss Charter on this special occasion.

A few months ago we welcomed the news that a school of nursing was to be opened in connection with the University of New Brunswick, under the capable guiding hands of Miss Katherine MacLaggan. Now the school is a reality and we are pleased to introduce two of the nurses who have recently joined the faculty.

Margaret G. McPhedran, associate professor, is a graduate of Charlotte Eleanor Englehart Hospital, Petrolia, Ont. with a Bachelor of Arts degree from the University of Toronto and a Master of Arts degree from Columbia University where she studied as the recipient of a W. K. Kellogg Foundation fellowship. In addition she obtained postgraduate preparation in nursing education at the U. of T. school of nursing. Miss McPhedran taught in schools of nursing in Saskatchewan and Ontario. During the years 1948-52, she was on the staff of the Demonstration School, Metropolitan Hospital, Windsor. Immediately prior to her present appointment she was assistant professor in nursing, University of Toronto School of Nursing.

MARGARET MCPHEDRAN

Irene Leckie, associate professor of nursing, graduated from the Provincial Mental Hospital, Ponoka, Alta. in 1948. She holds the degree of Bachelor of Science from the University of Alberta and, that of Master of Science from Wayne University, Detroit, Michigan. She received a graduate teaching fellowship for study in the latter institution.

Miss Leckie's experience has included a year as assistant superintendent of nurses at the University of Alberta Hospital and a

IRENE LECKIE

similar length of time there as instructor in nursing arts. During 1956-58 she was instructor in nursing at Wayne State University College of Nursing and for the past year had held the position of assistant professor of nursing.

Congratulations and good wishes are extended to Miss McPhedran and Miss Leckie. The inauguration of the University of New Brunswick School of Nursing has been a major event in Canadian nursing during this past year, and of interest to nurses across the country.

ADA SQUIRES

Ada Thomas Squires has been appointed director of nursing of Hamilton General Hospital. Born and educated in England, she is a graduate of this same hospital and thoroughly familiar with its organization. Shortly after her graduation Miss Squires became operating room supervisor at H.G.H., remaining in this role for 17 years. In 1942 she joined the RCAMC and was awarded the R.R.C. upon her discharge in 1946. Following her military service she went to Whitehorse General Hospital in the Yukon where she served as superintendent of nurses for some time. Two years as night supervisor at H.G.H. succeeded this appointment, and then Miss Squires became superintendent and administrator of the Nora Frances Henderson Hospital, Hamilton. She left this position to take on her present responsibilities.

Among her off-duty activities she counts one unusual and rather exotic hobby — growing orchids as house plants. She is a member of the Quotarian Women's Service Club and active in various professional organizations as well.

(Gaby of Montreal)

FLORANNA D. BRYANT

Floranna Dorothy Bryant has been appointed director of nursing, Queen Elizabeth Hospital of Montreal. She is a 1940 graduate of Q.E.H.M. and holds her certificate in teaching and supervision from McGill University School for Graduate Nurses. With the exception of brief periods, she has served on the staff of her hospital in several capacities since her graduation, most recently as instructor in nursing practice and as student health supervisor.

Possessed of a keen and continuing interest in nursing education, she has partici-

pated enthusiastically in the work of committees dealing with this topic. She is a past chairman of the Instructors Group, secretary to the provincial Curriculum Committee and chairman of the English section of the provincial Board of Examiners. Her duties as the director of a busy and expanding hospital plus the foregoing responsibilities leave a minimum of time for recreation. As time and opportunity permit, she enjoys travelling, exercising her talent for interior decorating, swimming, skiing, and "educating one budgie and one dog."

Joan Muriel Gilchrist is the new director of nursing of the Jewish General Hospital, Montreal. A native of Toronto, she attended school, was employed by the Bell Telephone Company and received her basic nursing education there.

Following graduation in 1950, Miss Gilchrist did general staff nursing at Wellesley, her home hospital, Victoria Veteran's Hospital, Victoria, B.C., and St. Ann's Hospital, Juneau, Alaska.

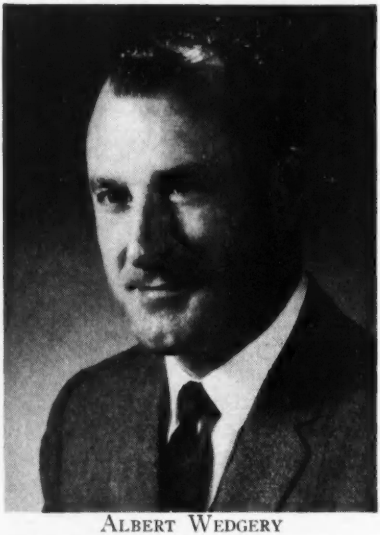
(Geraldine Carpenter)

JOAN GILCHRIST

Acquisition of her diploma in clinical supervision at the University of Toronto in 1953 helped Miss Gilchrist to prepare herself for head nurse responsibilities and later those of science instructor at Wellesley. The year prior to attending McGill University, she was a nursing office supervisor at the New Mount Sinai Hospital in Toronto. Following the completion of studies for a Bachelor of Nursing degree in Nursing Education, she returned to N.M.S.H. as assistant director of nursing education.

Miss Gilchrist has been active in nursing education with the Registered Nurses' Association of Ontario as convener of the working party on refresher courses and as a member of the sub-committee on examinations. As interested in her own education as that of others, she attended night classes through the Department of Extension of the University of Toronto.

Part of her leisure time for the past four years, has been taken up with her membership in No. 4005 Auxiliary Medical Unit, R.C.A.F., while the few hours that are left are spent in reading and golfing. Travel is another activity from which she derives much pleasure.



ALBERT WEDGERY

The Registered Nurses' Association of Ontario has added a new leaf to the pages of Canadian nursing history with the appointment of **Albert Wedgery** as assistant nursing education secretary. Mr. Wedgery becomes the first male nurse in Canada to serve on a provincial office staff. He is a graduate of Ontario Hospital, Whitby and obtained a certificate in teaching and supervision from the University of Toronto School of Nursing. For several years he did general duty in the operating room of Oshawa General Hospital and was subsequently appointed science instructor and clinical instructor in operating room technique. In 1956 he became the operating room supervisor of Oshawa General Hospital, leaving that post to accept his present duties. During World War II, Mr. Wedgery served in the Sick Berth Division of the R.C.N.V.R. in Canada and overseas.

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In 1956 when the Male Nurses' Committee was formed, he was appointed chairman and his efforts on behalf of the male nurses in Ontario are well-known. His staunch belief in the potential role of his colleagues in Canadian nursing has strongly influenced his professional activities. Congratulations are extended to him on this occasion in the knowledge that it will be a source of great encouragement to him in his attempts to gain recognition of the role that the male nurse can play in our profession.

Mary Alice Rita Doyon has been named assistant chief nurse, Department of Health, Montreal. A graduate of the Hotel Dieu Hospital, Cornwall, she obtained her certificate in public health nursing from McGill University, and a Bachelor of Science degree from Columbia University where she majored in supervision in public health nursing. She has, at various times, worked with the Child Health Association in Montreal, served as an industrial nurse with the Lake St. John Power and Paper Co. Ltd., and on the staff of the St. Lawrence Sanatorium, Cornwall. She joined the Department of Health as a supervisor prior to her present appointment.

RITA DOYON

Apart from her duties with this Department, Miss Doyon has been an enthusiastic supporter of the activities of the Red Cross Society, especially in the field of home nursing. She joined the Society as a volunteer instructor in 1948 and since that time she has been extremely active in the Home Nursing program. She was responsible for the organization of the University of Montreal Home Nursing Instruction at Montreal Branch headquarters whereby nurses attending that University obtained practical teaching experience in the home nursing classes. She continues to serve as consultant and advisor to each student-teacher in this program. In recognition of her services she was awarded the Red Cross Badge of Service in 1957.

(M. Karklin)

MURIEL E. NIBLETT

Muriel E. Niblett is the senior public health nurse for Weyburn-Estevan Health Region, Weyburn, Sask. She is a graduate of Estevan Hospital, and obtained her certificate in public health nursing from the University of Toronto School of Nursing. During World War II, Miss Niblett served in South Africa as a nursing sister. Following her discharge, she spent several years as an office nurse before entering the public health field.

Off duty she is an enthusiastic curler, and has a great interest in sports such as hockey and baseball. Quieter moments are used for handiwork that includes needlepoint.

'Tis with our judgments as our watches, none go just alike, yet each believes his own. — POPE

If one does not know where one is going, how then, is he to know when he has been there? — H. E. RICE

Voice of the Past

To modern nurses, the "old days" of the profession are regarded as an interesting facet of the early history of nursing, enlivening the pages of our history books but so far removed from the present as to seem almost fictional. And then, suddenly, we are startled to find that the past is not nearly so distant after all.

In September, 1959 the Sisterhood of St. John the Divine celebrated the 75th anniversary of the founding of its Canadian community. To Torontonians, the life and work of the sisterhood is a familiar story but others may not realize that this is the first — and still the only — religious order for women in the Anglican church that originated in Canada. Founded in 1884 by Mother Hannah, a widow, the Order pioneered in the fields of surgical nursing, development of convalescent hospitals, social services, homes for the the aged and work for retarded children. For 64 of those eventful 75 years, Sister Beatrice has been a member of the Order and her record of service has been an outstanding one. In 1954 she retired from hospital service, after she had attained the distinction of being the first member of the Community to reach her diamond jubilee — 60 years under Vows of Profession. Since then she has given devoted and valuable service as the convent librarian.

It is as we examine the events of her lifetime that we can see the past just over our shoulders. At the time of her birth in 1874, "Sairey Gamp" had not quite vanished from the nursing ranks. The Montreal General Hospital had begun its early efforts to found a training school and, in that year, Miss Nightingale's advice and practical assistance were requested. In 1884, when Sister Beatrice was in her eleventh year, the Order that she was eventually to join was founded and Miss Mary Agnes Snively, working at the Toronto General Hospital, had begun to lay the foundation upon which Canadian nursing was to build. By 1890, another great lady in nursing, Miss Nora Livingston, was directing the much-improved fortunes of the Montreal General Hospital School of Nursing. Six years later Sister Beatrice was received into the Noviciate of the Sisterhood of St. John the Divine and was immediately assigned to St. John's Hospital "to learn nursing." She proved an apt pupil. At the time of her retirement in 1954, she had risen to the rank of administrator of St. John's Convalescent Hospital.

St. John's Hospital began as a tiny institution "for the treatment of the Diseases of Women" — in other words, to provide gynecological service. The excellence of the care provided speedily attracted the attention of the medical profession and the influx of patients made new and larger accommodation imperative. Property was acquired in the then "new section" of the city and, in 1889, a new hospital with an adjoining convent was erected. There was one 12-bed public ward, seven private rooms, 3 semi-private rooms and an operating room. The building possessed all of the most up-to-date features of "modern" hospital construction of the day. The charge for indigent patients was $3.00 *per week;* for private rooms, $7.00 - $12.00 *per week!* Eventually units for general surgery and sick babies were added and the bed capacity rose to 75.

In 1934, increasing financial expense among other factors led to the Sisters to investigate the need for provision of convalescent care rather than general hospital care. Professors at the University of Toronto, the Lieutenant-Governor Dr. Herbert Bruce, and others encouraged the project, with the proviso that it was to be an *active, convalescent service* having close relationships with the general hospitals and offering a continuation of treatment received there. It was arranged that applications for admission would be made through the Social Service department of the various institutions concerned. St. John's Con-

We are indebted to Mother Aquila, Superior of the Sisterhood of St. John the Divine for supplying us with the historical facts presented in this article.

valescent Hospital was incorporated in 1936 and became one of the public hospitals of Ontario, and a model for convalescent hospitals in Canada generally. At present over 200 patients can be accommodated and every possible rehabilitative service — physical, mental and spiritual — is offered. An important feature is the library, containing some 2,000 books.

This story would not be complete without a description of the school of nursing that formerly existed in connection with St. John's. Who can do this better than Sister Beatrice?

When the new hospital building on Major Street, Toronto, was opened in 1889, the Sisters continued to do all of the nursing themselves by day and night. Gradually young women came in to assist as "Lady Helps." In return for their services they were "trained to nurse" and they received a small fee. Their hours of duty were from seven to seven, day or night. The day nurses had one-half day a week free, and (theoretically) two hours off duty daily. But no free time was alloted to those on night duty. Indeed they were required to sit in the room with a fresh operative case when not engaged in doing routine duties. Another order was that they should wear bedroom slippers after the patients were settled, to maintain the quiet necessary for the sick. A few of these young girls who began as "Lady Helps" remained on the staff for several years and became proficient nurses in their day. One of the first nurses on record to have received a diploma graduated in the year 1903, after fulfilling her three years of training. (It was mostly of a practical nature). She had many years of most successful private duty at the New York Hospital.

(Randal MacDonald Eaton's)
SISTER BEATRICE

The uniform of the School was a pink and white striped dress with kerchief and waist band apron. Later this was changed to include a stiff collar and starched bib. The almost round cap had ruching around its edge. It was a rule that everyone should wear laced boots. Short hair was prohibited until one member of the staff (a St. John's graduate who loyally supported the Sister's wishes) came to me with the pathetic tale that she was unable to buy a new hat as none were made to fit over a head of hair! There was only one reply to make — "Go and have your hair cut, child! So with a struggle we came up-to-date! Boots and long skirts came to the same end in their turn. Subsequently, a new cap which could be ironed flat and folded into shape before use, was substituted for the original model. Senior nurses were given an S.J.H. monogram to wear on their arm bands. This is still being worn by two or three nurses.

Candidates were received into the school singly for several years. The first class, graduated in the year 1917, had three members. Up to that date our nurses were obliged to take post-graduate courses in public hospitals to broaden their training. At the time this first class graduated, we were seeking affiliation with the training schools of Toronto General Hospital and the Hospital for Sick Children in order to include it within the three years. The next year's class (1918) and all subsequent ones had the benefit of it. However, before it was obtained, the theoretical instruction had to be brought into line with that of these hospitals. Members of our medical staff were approached. They promptly consented to supply the need for lecturers. The training schools of all hospitals were likewise depending upon the members of their medical staffs for lectures to their students. Eventually it was realized

that this involved much duplication of teaching and absorbed too much time of professional men.

Under the capable leadership of Miss Gunn, superintendent of nurses at the Toronto General Hospital, a plan was evolved by which eight of the standard subjects of the curriculum were given in lectures to the combined student groups of schools within a reasonable area. The lecture hall of the medical building of the University of Toronto was put at our disposal. In addition to the economy in time, this plan standardized the instruction. Ethics, anatomy, dietetics and chemistry were left as the responsibility of the home schools. The examinations papers were read by a committee consisting of representatives of each participating school. Each examiner kept to the same question throughout to ensure equality of judgment in estimating its value. When instructors from the new course instituted at the University were available, each school again became responsible for its own teaching program.

Before medicine came into its own, surgery had begun to make dramatic strides and to challenge the interest of young men entering the profession. It eventually gave rise to the "specialist." At the end of the last century private patients in hospitals were unknown. Sickness was dealt with in the home, including operations. These were mostly of a minor character.

With the coming of the trained nurse, surgeons began to appreciate the advantage of using the hospitals, and encouraged their private patients to do so. When I began my training at St. John's in 1896, no private patient would think of going to the operating room. Instead, a compromise was made and surgery was done in her own room.

The hour for operation was usually 10:00 A.M. At 7:00 A.M. the patient was taken into the sitting room and rested on a couch. Meanwhile the floor rug of her room was removed, the open bed was prepared and pushed into a corner, the furniture was carbolized, the water jug and basin and its accompanying small hand jug and basin were washed and filled. This was the doctor's "scrub up" spot. Dry mustard was placed here and rubbed on the hands to make them surgically clean! Clean (not sterilized) towels were laid on the different pieces of furniture. The bureau, being the largest object, was usually the sponge table. Four or five white jugs were filled with sterile water, and covered with towels soaked in a carbolic solution. They were left in the operating room until morning. Sea sponges were used. They were kept in readiness in covered jars containing a carbolic solution. The preparation of the sponges was a great trial. They often contained fine slivers of shell, like tiny flakes of glass, which got into the hands as one prepared them for use by putting them through many rinsings of water. Rubber gloves were unknown. Instruments were put into granite trays containing carbolic solution. At this early period of our history each surgeon provided his own instruments and sponges.

When possible, patients were sent into hospital several days prior to operation. From a psychological standpoint, it was considered that much of their nervous tension would be relieved if, on the eventful day, their environment and nurses were familiar to them. It also gave an opportunity to prepare the system by means of diet, laxatives and enemata. The target of postoperative treatment was to obtain an early peristalsis. There was frequently a fight for life. Abdominal surgery being in its infancy, the fear of postoperative peritonitis was a bogey. When drainage was needed a perforated glass tube, about six inches long, was inserted into the abdominal cavity and at specified intervals a rubber catheter with a suction bulb attached, was put down the tube and the amount of serum drawn up was measured in a graded china spoon and recorded on the chart. Between treatments this appliance was kept in a bichloride solution. It is hardly necessary to relate that the patient sometimes developed a hernia as the result of the retarded healing caused by the tube! In the course of time rubber tubing was substituted for the glass tube, suction was discontinued and nature was left to do her own work.

Two other customs are worth mentioning. The patient was kept routinely on her back for several days lest the ligatures that clamped the blood vessels should give way. She was not allowed water or fluids of any kind for a day or two in the belief that it would increase vomiting and, further endanger the hold of the sutures. Experience, that great-

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est of all teachers, has taught us much of nature's healing power since that day. It is indeed a far cry from the precautions of those earliest ventures in the beginning of this century to the assured confidence of the present time that sees a patient out of bed within a few hours of operation!

It was at the instigation of the medical staff that, when we were preparing to open a new operating room suite in 1915, I was sent to the U.S.A. for intensive observation. I visited the operating rooms of New York and Philadelphia hospitals, and the Johns Hopkins Hospital, Baltimore. I returned prepared to set up the new suite and adopt the best techniques as yet discovered. As superintendent I continued to attend all operations until such time as a nurse took over in 1922. Early in the century the Mother Foundress introduced white habits for the nursing Sisters, an appropriate action that was subsequently adopted in other Sisters' hospitals. In 1922 we opened an outpatient department in a downtown parish as a memorial to the men who gave their lives in the First World War. In 1937 the Toronto Western Hospital took it over.

While my personal experience is limited to surgery in an intensive degree, and that is the angle from which this resume is made, I am not unmindful of the fact that the discoveries in medicine have been equally as dramatic. The x-ray, vaccines, antibiotics, anesthetics, etc., have revolutionized medical practice. All this has come about within the last few decades.

Sir Arthur Grimble when holding office for the British Government in the Gilbert Islands, relates his experience of being initiated into one of the tribal clans as "a member of the family." Following a very painful tatooing he was addressed by the leader in these words: — "Our roots are the generations of old. Know the roots and thou shalt know the tree. Know the tree and behold! it shall answer to thy cultivation." Perhaps there is something for us to learn from this sage advice!

Sister Beatrice is outstanding both as a Religious and as a nurse. Her influence upon those with whom she has come in contact has been profound. Her greatest achievement has been the part that she has played in the development of the surgical treatment of diseases of women and convalescent care. Her outstanding work has been in the field of hospital administration, in the development of the educational program of her hospital, in outpatient department organization, in research in convalescent care, and in supervision and organization, in research in convalescent Convalescent Hospital.

This is our anniversary tribute to her and to the Order that she represents with such excellence.

White Mop Wringer Company of Canada, Paris, Ontario, has just published a new catalogue of floor cleaning equipment that illustrates a complete line of mechanical floor cleaning equipment and maintenance accessories. It also includes useful information on the floor maintenance applications of each of the items of wringers, squeezers, buckets, trucks, tanks, squeegees, mop sticks, dust pans, utility trucks and mopping outfit combinations.

* * *

The magic of the tongue is the most dangerous of all spells.

— HENRY GLASSFORD BELL

* * *

Every man who is very high up loves to think that he has done it all himself; and the wife smiles, and lets it go at that.

— JAMES M. BARRIE

* * *

Just stand aside and watch yourself go by;
Think of yourself as "he" instead of "I."

— STRICKLAND GILLILAN

In Memoriam

Bérangère Anctil who graduated from Notre Dame Hospital, Montreal in 1927 died in August 1959. Her professional career had been devoted to industrial nursing.

* * *

Edith (Williams) Chorley, a graduate of Pembroke Cottage Hospital, Ont. in 1914, died on May 28, 1959 after a long illness. Private nursing and service with the Victorian Order of Nurses occupied much of her professional life.

* * *

Cecile Dupré, a graduate of St. Jean de Dieu Hospital, Montreal in 1925, died recently.

* * *

Isabelle Fairfield who graduated from Toronto General Hospital in 1929 died on September 23, 1959. During World War II she served overseas with the 15th General Hospital Unit. In 1947 she was awarded the Royal Red Cross. Following her return to civilian life she joined the Ontario Society for Crippled Children and was responsible for the organization and direction of the Society's program for its camps.

* * *

June (Stunden) Gardner, a graduate of the Royal Victoria Hospital, Montreal in 1952, died during the past summer.

* * *

Alice Hayes, who had just completed her first year as a student nurse at Stratford General Hospital, Ont. was drowned recently.

* * *

Mabel (McColl) Leggett, a graduate of the Lady Stanley Institute, Ottawa in 1911 died September 5, 1959.

* * *

Emily (Miller) McManus, a graduate of the Royal Alexandra Hospital, Edmonton in 1911 died on June 11, 1959. She served overseas during World War I with the Canadian Army Medical Corps and was one of the first members of the Overseas Nursing Sisters' Association. She was the night supervisor at R.A.H. for some time prior to and following her military service.

* * *

Jean Lundy, a graduate of St. Joseph's Hospital, Chatham, Ont. in 1909, died in August, 1959. She had engaged in private nursing for 42 years.

* * *

Sister Anita Roy a graduate of the Hôtel Dieu of St. Joseph, Campbellton, N.B. in 1946, died on September 4, 1959 from injuries received in a car accident. At the time of her death she was the Superior and administrator of the Hôtel Dieu of St. Joseph.

* * *

Ila Mae Smith who graduated from the University of Alberta Hospital, Edmonton in 1954 died on September 14, 1959. She had just completed the requirements for her Bachelor of Science degree in nursing at the University of Alberta when stricken with her final illness.

* * *

Anne C. Stark, a graduate of the Royal Victoria Hospital, Montreal, in 1914 died on September 21, 1959. She had served overseas with No. 3 Canadian General Hospital during World War I.

* * *

Mrs. Katherine Louise Watson, a graduate of Newport School of Nursing, Newport, Rhode Island died recently in West Vancouver. She was a nursing sister in the Canadian Army Corps during the First World War and served in military hospitals in Canada and England.

* * *

Lillian E. (Furey) Young who graduated from St. Joseph's Hospital, Hamilton in 1914, died on July 20, 1959.

How many desolate creatures on the earth have learnt the simple dues of fellowship and social comfort, in a hospital.

— Elizabeth Barrett Browning

* * *

For after all, the best thing one can do when it is raining, is to let it rain.

— Longfellow

The highest possible stage in moral culture is when we recognize that we ought to control our thoughts. — Charles Darwin

* * *

And when you stick on conversation's burs,

Don't strew your pathway with those dreadful *urs*. — Oliver W. Holmes

To Use or Not to Use

THE TOURNIQUET has been with us for about as long as the hot soak, but even today it is the subject of much controversy and confusion.

Many decry its use. Others consider it indispensable. Some label it a technique of last resort. A few exhort that it should be used without delay. We are told that it can be used only above the knee or elbow. Experience, however, proves that it works at the wrist and in midcalf. We are told, "It must be loosened every 20 minutes." And again, "Put it on and leave it alone."

We are often taught that the tourniquet is a last resort; that it is to be used only if all other methods have failed. So we try elevation and a pressure dressing. What if these methods fail? Then we use a tourniquet. In the meantime the trial and the failure may have cost the patient another unit of blood. And that may be the last unit he has left to spare before his compensation breaks and he goes into profound shock. No, the tourniquet is *not* the last resort. Its application may be the least desirable method, but it is not the last resort. *When there is bleeding from a major artery of an extremity, and when your judgment tells you that a pressure dressing will not hold it adequately, then use a tourniquet without delay.* There is no time for trial and error.

A blood pressure of 120 millimeters of mercury is equivalent to a column of blood (or water) about five feet high! Suppose we have a woman who has lacerated a radial artery. We place her supine on the floor. We elevate her extremity as high above the level of her heart as is anatomically possible. She will have to bleed down to a pressure of 40 millimeters or so before elevation alone will control the bleeding!

Whenever there is an amputation stump or an open wound with a severed major artery, the only effective means of control of hemorrhage are: the tourniquet, digital pressure, clamping or ligation.

A tourniquet is admittedly a hazard to the viability of the limb. For that matter so is a tight compression dressing. Perhaps you have seen the tragic aftermath of a blood pressure cuff inflated and forgotten for hours. Or the complication of a constricting plaster cast. Obviously a tourniquet can do the same thing. That hazard must be considered when you are deciding to use a tourniquet. But if the hemorrhage is a threat to life, you must accept the threat to the limb.

When you put a tourniquet on, *do not loosen it until it is no longer needed.* That time has come when the patient is in the operating room ready for surgery, or in the emergency room with clamps and ligatures ready, or when reconsideration leads to the conclusion that a tourniquet is not indicated. Then it comes off, but it is not loosened at any periodic intervals. A few moments of loosening may cost a liter of blood, particularly if you have been treating the patient and have raised his blood pressure in the meantime!

Not only do you not "loosen" a tourniquet, you take pains to put it on tightly in the first place. It takes care to put a tourniquet on correctly. It is usually painful to the patient (if he is conscious and not in deep shock) if it is as tight as it should be.

Just how tight must it be? The only way to learn this is to try it on yourself. Feel for your own dorsalis pedis artery. Put a tourniquet on your thigh. Twist it until it begins to hurt. Feel again for the dorsalis pedis. Chances are it is still pulsating. You will have to twist some more! When you put a tourniquet on a patient, the answer is not always to "tighten until the bleeding stops." It may have been stopped already — by a precariously loose clot, or by a dangerous degree of hypotension. An amputation stump needs a tourniquet even though it is not dripping blood when you first see it.

The tourniquet is a useful device, but it is not *used* often enough. It is often *misused.* Here are the rules:

1. Use a tourniquet as soon as your judgment indicates that elevation and dressings will not do the job — do not prove the point by trial and error.
2. Put it as *low* on the limb as possible.
3. Put it on *tightly* and *do not loosen* it.

A tourniquet can save a life. Perhaps your own!

DOUGLAS LINDSEY, M.D.
American Journal of Nursing.

You can tell the ideals of a nation by its advertisements. —GEORGE DOUGLAS

Not to advance is to go back.
— Latin Proverb

Her mother might help, but

SHE'D RATHER TALK TO YOU ABOUT PIMPLES

Only two people easily available to the adolescent can offer advice with assurance that it will be gratefully accepted. One is the mother and the other is the nurse in school, doctor's office, or elsewhere. Actually, the nurse, because of her professional stature and knowledge, can help where a parent often fails.

There is now a clinically-proved medication for pimples* which you can recommend with confidence...CLEARASIL Medication. Many nurses do in fact suggest CLEARASIL —as a recent survey of readers of *RN, A Journal for Nurses,* indicates.

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Each package of CLEARASIL contains an authoritative, helpful leaflet on general skin hygiene and living habits. CLEARASIL is guaranteed to help clear skin fast or money back. 69¢ or $1.19 at all drug counters.

For FREE, PROFESSIONAL SAMPLE of CLEARASIL and copy of clinical report, write CLEARASIL, Dept. N-3, 429 St. Jean Baptiste St., Montreal. (Expires Feb. 1, 1960).

**Original clinical reports in our files.*

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Canadian Tuberculosis Association Annual Meeting

When the Canadian Tuberculosis Association met in Halifax last spring, the Nursing Section held its sixth annual meeting with representation from British Columbia to Newfoundland. In the reports of the provincial representatives, certain similarities were evident. There was an increasing number of older patients and in some areas an increasing number of children. It was the difficult patient with special problems who was remaining in hospital and so, despite lowered bed occupancy, the demand for professional nursing care was just as great and in some areas greater than ever before. Because special skills are required of those who work with these patients, it was felt important to emphasize the need for the continuing education of staff members in order to maintain high levels of service.

In most places, the number of patients in hospital was less. This was due to a shorter stay in hospital rather than an actual reduction in the number of patients. This has increased the need for more concentrated patient education. Although the death rate has declined markedly, the morbidity rate has been at a virtual standstill for the past several years with new cases being reported at a rate of nearly 9,000 a year. It would seem therefore, that more effort must go into the work of prevention if we are to continue our advances in the control of this disease.

There was considerable discussion regarding affiliation of student nurses in tuberculosis nursing. The length of these courses varies from one week to two months. It was agreed that we need to examine our aims and practices to determine whether they are truly educational and to adjust them so that they comply with changing patterns of care. It was also agreed that in all teaching the emphasis should shift to the case-finding and preventive aspects of the program giving special recognition to the key role of the public health nurse.

Next year, the Canadian Tuberculosis Association will hold its sixtieth annual meeting in Ottawa. We look forward to representation at the nursing section from all parts of Canada.

MADGE MCKILLOP,
Montreal.

Emotionally Disturbed Patients

Due to the constantly increasing number of patients with psychiatric problems who are being admitted to general hospitals, the nursing staff at the Edmonton General Hospital expressed a need for better understanding of this type of patient. The need was probably increased because many of the nurses have not had the opportunity of psychiatric affiliation.

In view of this situation, a two-day institute on "Nursing Care of the Emotionally Disturbed Patient in Hospital Today" was held last June. The purposes of the workshop were.

1. Modification of our attitude toward patients with emotional disturbances, by gaining an understanding of the problems involved in their nursing care.

2. Need for renewed emphasis on mental hygiene due to the large number of emotionally disturbed patients we are treating.

3. To review the principles and techniques of treatment of the emotionally disturbed patient.

4. To aid the nurse in anticipating, identifying and relieving symptoms of emotional disturbances by demonstrating the dynamics of human inter-relationships.

5. To stimulate growth and interest of our nursing staff in psychiatry and related fields.

Psychiatrists, doctors, social workers and nurses were in the group of guest lecturers, all of them active in various aspects of psychiatry.

Arrangements were made within the departments for the release of the nursing staff. This cooperative effort made possible the attendance of all who desired to be-

come informed. The subject material presented was stimulating and interesting.

It was pointed out that childhood experiences are very important in the determination of future emotional problems; also that all patients admitted to the hospital have emotional, as well as physical problems. The nurse receiving the patient can do much to alleviate or aggravate these anxieties by her manner and attitude.

The emotional reaction the patient has toward the nurse, in the form of dependency or hostility and aggression, was well depicted. It was also shown that emotion begets like emotion; for example, when a patient shows hostility to the nurse, hostility may be shown in return. The hostility increases in subsequent contacts. The nurse can overcome this situation, first by having an understanding of herself and her emotions; secondly by controlling these reactions and displaying kindness and understanding instead. The old adage, "smother your enemies (patients) with kindness" is suitable in these cases.

The principles of electrotherapy and insulin therapy were outlined and the nursing care of the patient was discussed in detail. Emphasis was placed on the role of the nurse which is to give support and reassurance.

The care and treatment of the emotionally disturbed patient involves moral implications and responsibilities. The non-judgmental attitude of the nurse was stressed and clarified. Discussion was encouraged and this active participation was enjoyed by the group.

An evaluation of the benefit accruing to those attending was made and the response was gratifying. The 120 nurses indicated that this was an excellent method of practical problem-solving, with the assistance of experts in the field. The nurses also expressed a desire to increase their knowledge and improve patient care by having institutes of this kind more often.

Having met with such success, it is felt that this form of inservice education in similar hospital situations would stimulate greater interest in current trends of nursing, not only for those actively engaged in nursing, but for those who are not actively employed.

(Mrs.) B. Ward, R.N.

Book Reviews

Fundamentals in Nursing Care by Mildred L. Montag, Ed.D., R.N. and Ruth P. Stewart Swenson, M.A., R.N. 581 pages. W. B. Saunders Company, West Washington Square, Philadelphia 5. 3rd ed. 1959. Price $5.00.

Reviewed by Miss Helen McHale, Clinical Instructor, Hotel Dieu Hospital, Moncton.

Fundamentals of Nursing Care is a complete and concise study of the principles underlying nursing care. It is refreshingly different in its presentation with emphasis placed on normal body functioning and health teaching contrasted with variations that occur in illness and the care thereof. Although the introduction or orientation to nursing is rather detailed the remainder of the book shows no such digressions.

The integrated subject matter restricts itself to principles rather than details of methods and procedures; this makes it adaptable to almost any situation.

The illustrations are both pertinent and descriptive. For example, the illustrations on body mechanics show not only pictures but diagrams relating to specific movements.

There are, however, two technical points which require some clarification. One of these (p. 87) suggested the use of boric acid solution in the care of an artificial eye. In view of present medical thinking regarding the use of boric acid solution this point is questioned. The second point (p. 279) is as follows, "There is a new preparation of insulin which may be administered orally." The new preparations used in treating diabetes such as orinase are antidiabetic hormones and are *not* preparations of insulin.

The major objective of the authors in rewriting the book is to answer the question "What does the nurse need to know in order to give good nursing care?" This question is continually asked by those concerned with nursing education. The authors have accomplished their purpose remarkably well in this comprehensive study of the principles underlying the nursing care of patients whether at home or in hospital. This book is there-

fore recommended as a valuable aid for nursing instructors and students.

The Psychiatric Aide by Alice M. Robinson, R.N., M.S. 200 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 2nd ed. 1959. Price $3.50.

Reviewed by Miss Edith Kemp. Director of Nurses, Provincial Mental Hospital, Ponoka, Alta.

This book is written primarily for the psychiatric aide; the approach is very good concerning itself mainly with relationships between people and the attitudes that are the essential tools used in modern psychiatric treatment.

The author has been successful in presenting material in a simple, meaningful way that is both positive and stimulating. There is close correlation between fundamental psychological principles and their practical application in every day care of the mentally ill. There is enough history to make the reader feel enthusiastic about the tremendous progress that has been made in psychiatry in the past 20 years. The role of the aide is depicted as an important and satisfying one, with encouraging prophecies of improved working conditions.

Attitudes are stressed throughout. There is a brief description of normal growth and development and the use of defense mechanisms. Accepting the patient and understanding his behavior is emphasized, with practical illustrations, both word and sketch. Enough information is given about special therapies to make them meaningful to the aide. The revised edition has omitted lobotomy and hydrotherapy and added group and individual therapy, the ataraxic drugs, and industrial therapy. Consideration for the individual patient is stressed and precautions are clearly stated, giving good examples. The importance of a healthy and safe environment is well stated, giving suggestions for organizing work in order to obtain the best results for the patients and to prevent accidents.

An excellent chapter has been added describing the aides' role in newer developments in psychiatric nursing — communication and human relations, remotivation, rehabilitation and "open door" policy. Relationships and the art of communication are presented in such a way that the reader is made aware of the importance of understanding himself in order to function effectively with the patient.

The author has succeeded in her objective to provide a text that will assist the aide to develop a better understanding of his own and his patients' attitudes, feelings, and behavior and guide him in his role as a therapeutic tool in the care of the mentally ill. This book should be useful for inservice educational programs in mental hospitals and for student nurses; it could also be useful in an orientation program.

The aides' place in the nursing team should have been discussed; its omission may reflect the fact that there are so few nurses in some of the large mental hospitals.

First Studies in Anatomy and Physiology by John Cairney, D.Sc., M.D., F.R.A.C.S. and John Cairney, B.Sc., M.B., Ch.B. 223 pages. N. M. Peryer Limited, Christchurch, New Zealand. 2nd ed. 1959. Price 30/.

The purpose of this elementary text is to provide a sufficient presentation of anatomy and physiology for groups of students whose course in nursing is shorter than that of the registered nurse. The authors state that this text is not to be regarded as a substitute for a text in anatomy and physiology that is necessary as a basis for the study of medicine and surgery.

This little book is well written, easy to understand and the illustrations are excellent. The larger part of the content is devoted to anatomy although the title would imply equal discussion of both anatomy and physiology. The need to supplement this text with others will depend on the course content of the individual teacher.

The amount, selection, and simplicity of content would qualify this text for use in schools for nursing assistants, practical nurses or trained attendants.

Introduction to Human Anatomy by Carl C. Francis, A.B., M.D. 548 pages. The C. V. Mosby Co., St. Louis, Mo. 3rd ed. 1959. Price $5.75.

Reviewed by Mrs. Grace Bobey, Instructor, University of Alberta Hospital, Edmonton, Alta.

The author stated that his purpose in writing this book was to "describe simple human structures in an understandable fashion." To this end he has presented the material in the traditional system pattern with practical applications and functions added that stimulate interest and make the facts assume more importance for the learner.

Pictures and diagrams help the reader to grasp the material more readily. The pictures of movements which occur at joints

illustrate terms such as flexion and extension very clearly.

In some areas extra headings would have avoided any possible confusion. There is not a clear division between gross and microscopic structure in the discussion of the kidney. In the section on the endocrine glands there is no heading to indicate where glands of known endocrine function end and those of possible endocrine function begin.

As an instructor's reference in anatomy this book is valuable; however, because anatomy and physiology are usually taught as one course in the nursing curriculum, the book would probably not be suitable as a text for student nurses.

Gynecology and Gynecologic Nursing by Norman R. Miller, M.D. and Hazel Avery, A.B., R.N. 447 pages. W. B. Saunders Company, Philadelphia. 4th ed. 1959. Price $5.50.

Reviewed by Mrs. Elva Crawford, Clinical Instructor, Royal Victoria Montreal Maternity Hospital, Montreal, Que.

This text will be familiar to many instructors of gynecological nursing. In the previous editions, the authors have given specialized coverage of the care of the gynecological patient, with detailed descriptions of such subjects as benign and malignant lesions, infections, and menstrual dysfunctions.

The book has been augmented by chapters on the psychology of gynecology, gynecology of infancy and childhood, gynecologic geriatrics, and terminal care of the advanced cancer patient. The last of these was particularly impressive. Minor changes include rearrangement of the material to provide better sequence, rewriting, and extensive revision throughout.

The authors rightly stress the fundamentals of and reasons behind nursing care, rather than providing complicated descriptions of procedure. Health teaching for the patient has been included in the nursing care material. The fourth edition, like the previous ones, is very clearly illustrated with pen and ink sketches, some completely new.

Further revision of the presentation and content of the chapter on irradiation would be an improvement. As in any detailed text, there are some statements which might annoy the specialist by their lack of completeness, but these do not detract from the book as a whole.

Not only instructors, but also students of gynecological nursing will find the text useful as a reference.

In the Good Old Days

Of all individuals connected with the hospital, none can do more to disturb its peace than the nurses and orderlies. Those who show a lack of suitable temperament and of sound, sensible dependable qualities, and who persist in disturbing the wards by boisterous behavior and frivolous conduct, show a glaring want of consideration for their patients and must undergo careful training to eradicate these defects.

* * *

When we work with others, we should know them in order to work effectively. It is amazing the number of people the public health nurse finds interested in the health game. If she is inexperienced, a good plan for her to follow is to list the people who are, or should be, interested in the health of the baby, school child, or adult, in whom she happens to be interested. She might at the same time, compile a list of the individuals and organizations interested in the health of the community, recording also the reason for their interest and possible influence they might exert. As her knowledge of the community deepens, the list will grow in length and interest.

* * *

Don'ts for the private duty nurse:

— don't imagine that you can discipline a patient in his own home as you would in a hospital ward. It can't be done.

— don't expect your patients to provide you with special appliances or tools for your work. Every doctor has his own appliances, every carpenter and plumber has his set of tools. Have yours too.

— don't forget to study your patient. Humor his likes and dislikes when it makes no difference.

The Lady Stanley Institute for Trained Nurses

A permanent record of the history of the "Lady Stanley Institute for Trained Nurses" has been preserved in book form by MRS. MADGE MACBETH of Ottawa. This Institute, established in 1889, differed from other training schools of that period in Canada by being independent of a hospital.

This volume is concerned mainly with the history of the Institute but there is more to the book than that. Included is the history of the founding of early hospitals in Ottawa and the need for competent nurses to care for the sick.

In 1901 the Institute was taken over and maintained by the County of Carleton General Protestant Hospital, with which it was amalgamated by Act of Parliament, but did not lose its identity. Eventually the Hospital and the Institute were merged in the Ottawa Civic Hospital.

This is an interesting book with numerous photographs of the various buildings and personages connected with the Institute and the Hospital. The names of many famous early Ottawa nurses and doctors pass through these pages.

An active Lady Stanley Institute Alumnae Association still exists. It was instrumental in the publication of this history. Copies may be obtained by writing to **Mrs. Pearl Bryce, 61 Ossington Street, Ottawa, Ontario.** Price $4.00.

A Diamond Jubilee

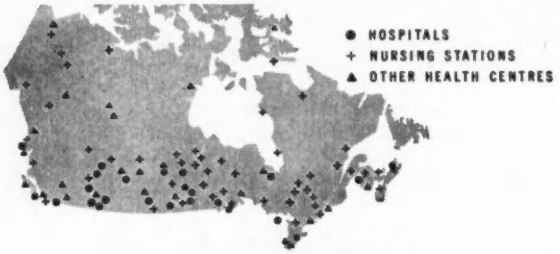
The alumnae association of the school of nursing of St. Joseph's Hospital, Victoria, B.C. is planning a "homecoming" to observe the 60th anniversary of its founding. This will be held at the hospital June 15-19, 1960. If you are a graduate of St. Joseph's, start planning now to be present for this very special occasion in the life of your school of nursing.

* * *

I leave this rule for others when I'm dead,
Be always sure you're right — then go ahead.

— DAVID CROCKETT

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

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(4) **Hospital Staff Nurses: up to $3,540 per year depending upon qualifications and location.**

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For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Employment Opportunities

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy and cancellations: **Six weeks** prior to date of publication. All letters should be addressed to: The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Quebec.

ALBERTA

Matron for 32-bed hospital. Reply stating salary required & experience. Apply: Secretary, Macleod Municipal Hospital, Fort Macleod, Alberta.

Registered Nurses or Graduate Nurses (2) for General Duty in 16-bed hospital. Salary schedule according to the current A.A.R.N. suggested schedule. Basic salary $255 for R.N. plus increment increases according to experience. Hospital is centrally located between two (2) lake resorts etc. Apply to: Mrs. J. Bergquist R.N., Matron, Municipal Hospital no. 43, Bentley, Alberta.

Public Health Nurse (Qualified) for rural Health Unit in Alberta. Salary range from $3,180 - $3,660 with annual increment of $120, transportation is provided on duty, provision made for sick leave & holidays, pension plan is available. Apply to: Dr. K. A. Barrett, Medical Officer of Health, Minburn-Vermilion Health Unit, Vermilion, Alberta.

General Duty Nurses (2-immediately) for 21-bed hospital, $250 per mo. plus room, board & laundry, 4-wk. vacation with pay after 1-yr. service. Increments of $5.00 every 6-mo., sick time accumulative 1½ days per mo. **Matrons position** will be vacant next June. Anyone interested apply: E. A. Richardson, Matron, Municipal Hospital, Berwyn, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: **The Matron**, Municipal Hospital, Bassano, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

Registered Nurses for General Duty in 25-bed new Hinton Municipal Hospital (to open December 1, 1959) & new nurses' residence in a busy pulp mill town on the Jasper-Edmonton Highway. Salary $275 per mo. less $35 per mo. for full maintenance, 40-hr. wk. Policies according to the Alberta Assoc. Reg. Nurses. Apply to: The Matron, Box 130, Hinton, Alberta.

Public Health Nurses (2) Salary range $3,630 - $4,158 according to experience. Car provided, pension, M.S.I., Blue Cross, etc. Apply: Dr. J. B. Sherman, Health Unit # 21, Peace River, Alberta.

BRITISH COLUMBIA

Operating Room Supervisor for modern 154-bed General Hospital. Please reply stating age, qualifications & experience. Salary based on above. **General Duty Nurses.** Generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

Nursing Supervisor (B.C. Registered) for new 26-bed General Hospital opening January 1960. Starting salary $335 per mo. Consideration given in deciding salary to past experience & postgraduate courses. Full maintenance $48 per mo. in new modern nurses' home. Scenic location, excellent working conditions, friendly surroundings, for full particulars write: C. F. Collins, Secretary, Golden & District General Hospital, Golden, British Columbia.

Laboratory Technician (1) Graduate Nurses (3) for 41-bed hospital. Starting salary for R.N.'s, $265 per mo., $255 till registered. 40-hr. wk., 10 statutory holidays, 28 days paid vacation after 1-yr. service, 1½-day sick leave per mo., uniforms laundered. Apply: Sister Superior, Providence Hospital, Fort St. John, British Columbia.

Registered Nurse for new 26-bed General Hospital in the Fraser Valley, 100-mi., from Vancouver. Accommodation available in new residence. Apply: Director of Nurses, Fraser Canyon Hospital, Hope, British Columbia.

Registered Nurses (3) for 30-bed hospital in Central B.C. on the Jasper-Prince Rupert Highway, 70-mi from Prince George. Salary $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Also **Certified Practical Nurses (3)** salary $190 per mo., 1½-days sick leave per mo. 10 legal days with pay per year; 2-wk. vacation after 1-year. Kindly apply giving qualifications & references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

Registered Nurses (3) for 30-bed hospital. Starting salary $270 per mo. with $10 yearly increment. Past service recognized for salary purposes. Board & room $40, 1½ day sick leave per mo. 40-hr. wk. 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for small active hospital. Salary $250 for unregistered, $260 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. **Nurses Aides** — with vocational training. Salary $167-$190 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed General Hospital located in British Columbia's beautiful Northwest. Salary $283 per mo. with $10 increments for 3 years. Modern residence facilities available. For complete information apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses: starting salary $288 if 2 yr. experience, $275-$330 in 4 yr. Non registered $260. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for general duty (2) for 27-bed Community Hospital. Salary: $280 per mo. with 3 annual increments of $10 per mo. Room, board & laundry $40. 28-days vacation after 1-yr. service. Graduate complement 6. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., with semi-annual increments of $5.00 - $305. 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo. Lodging $11 per mo., full board $33 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses for 25-bed hospital, 35-mi. from Vancouver on the coast. For salary rates & personnel policies, apply to: Director of Nursing, Squamish General Hospital, Squamish, British Columbia.

MANITOBA

Supervisors & General Duty Nurses (Female) for Clearwater Lake Hospital, The Pas, Manitoba & Manitoba Sanatorium, Ninette. Salary range $265 - $295 depending on qualifications & appointment. Effective January 1st salaries will be revised upwards. 3-wk. vacation, 40-hr. wk. 10 statutory holidays, group insurance plan. Interesting nursing with white, Indian & Eskimo patients both in general & tuberculous wards. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Manitoba.

Registered Nurse to act as Matron in 10-bed rural Hospital. Minimum salary $320 per mo. For full particulars apply to: Secretary-Treasurer, Box 235, Fisher Branch, Manitoba.

Registered Nurse for duties of Matron, for 11-bed hospital, 7-bassinettes, good salary & conditions. Apply: Superintendent, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurse (for general floor duty). Salary $290 per mo. less $25 for full maintenance, yearly increments, 44-hr. wk. For further information apply to: John Hiscock, Secretary-Treasurer, Baldur Medical Nursing Unit, Baldur, Manitoba.

Registered Nurse (1—Immediately) for 11-bed hospital. Salary: $300 per mo. with increments, less $25 per mo. full maintenance, living quarters in hospitals. Please apply to: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurses, Licensed Practical Nurse for 15-bed mission hospital. Starting salary $270 & $180. Daily bus service to Winnipeg. Apply: Superintendent, Elizabeth M. Crowe Memorial Hospital, Eriksdale, Manitoba.

Registered Nurse (1) Licensed Practical Nurse (1) for 30-bed hospital. Salary $270 & $195 per mo., respectively with $5.00 increases every 6-mo. Excellent working conditions; 40-hr. wk., overtime pay; living quarters. Apply stating age & qualifications to: Mrs. R. Maiers, Superintendent, District Hospital, Roblin, Manitoba, or phone 180 collect.

NORTH WEST TERRITORIES

General Duty Nurses (2) for 44-bed hospital in progressive northern gold mining town. Salary $267.50 with $10 increments yearly for 3-yrs. Maintenance $25, 1-mo. annual vacation. Transportation, Edmonton - Yellowknife plus freight on 100 lbs. of baggage provided. Apply: Director of Nursing, District Hospital, Yellowknife, N.W.T.

NOVA SCOTIA

General Duty Nurses (4) Operating Room Nurse (1) for well equipped modern 20-bed hospital on scenic Eastern Shore of Nova Scotia's mainland. Salary in accordance with scale set by R.N.A.N.S. Contact: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1-yr Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

ONTARIO

Operating Room Supervisor (Immediately) for 86-bed hospital. Good salary, employee benefits & statutory holidays, living accommodation available in residence. Locate in Collingwood & enjoy its many winter sports along with excellent swimming & other summer activities. Apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Head Nurses (2) for Medical Units — previous supervisory experience essential, good personnel policies. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

Registered Nurse as Superintendent (Immediately) for 30-bed hospital, stating previous experience & salary expected. Furnished 3 room apartment provided. Apply to: Secretary, Englehart & District Hospital Board, Box 609, Englehart, Ontario.

Assistant Superintendent with X-Ray experience for 31-bed General Hospital. **Apply:** Supt., Louise Marshall Hospital, Mount Forest, Ontario.

Registered Nurses for 50-bed Hospital, Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurse (1-immediately) for Margaret Cochenour Memorial Hospital (modern 15-bed) located on lake in Red Lake mining & tourist area. New nurses' residence beautifully furnished. Salary $300 basic with increment plan. Maintenance including uniform laundry, $30 per mo., 44-hr. wk., holidays, 4-wk. vacation with pay yearly, transportation expense will be paid after 6-mo. employment. Apply stating age & references: I. MacNaughton, Matron, Cochenour, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital. Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for Canadian Army. Officer status. Salary starts $275 - 6-mo. $375 - 3-yr. $409. Regular Staff duties & opportunities for specialization; 30 day leave per year with pay, free medical & dental care; full pay when hospitalized; excellent pension plan for career officers, retirement 45-49. Opportunities for travel. For particulars apply: Army Headquarters, (D Man M2) Ottawa, Ontario.

Registered Nurses (Toronto Area) for 30-bed hospital for chronic illnesses. Salary $12 per day; 5-day wk.; 3-wk. vacation per year. Apply: L. Mackie, Director of Nursing, The Villa Private Hospital, Box 490, Thornhill, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $255 & $180 respectively with regular annual increments for both. Excellent personnel policies & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for General Duty. Salary commensurate with experience & qualifications. Apply: Supt., Louise Marshall Hospital, Mount Forest, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for Surgical Floor in 163-bed Sanatorium. Excellent personnel policies. Residence accommodation available. Apply: Director of Nursing, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses for General Duty Staff. Salary $260 per mo., ideal community, winter & summer recreation. Apply to: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario.

Registered Nurses (2) for General Duty in modern 90-bed hospital, salary $255 per mo. 3 annual increments, accumulative sick leave. Excellent recreational facilities in town near cities & resorts. Room & meals at reasonable rates. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Duty Nurses for modern hospital, building expansion under way increasing to 100-beds this year. Starting salary $250 per mo., $215 for Graduates. 40-hr. wk., group life, accident & sickness insurance free to employees. Opportunities for advancement, pleasant community. Apply: Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

Registered General Duty Nurses for 28-bed General Hospital. Starting salaries $255-$270 according to qualifications, 40-hr. week, good personnel policies. Adjacent attractive residence available. Room & board $40; recreation facilities. For further information please apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

Registered General Duty Nurses (4) Certified Nursing Assistants (2) replacements for ones who have been married. For 105-bed hospital in a town of 15,000 population. Gross salary ranges from $210-$240 with annual increments. 3-wk. vacation, 7 statutory holidays, Blue Cross medical/surgical participation, 14-day sick leave, no night duty. except in Obstetrical Dept. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active, interesting community social life in the heart of the beautiful Ottawa Valley. Active Ski, Curling & Golf Clubs, also the home of the famous Pembroke Lumber Kings Hockey Team. 2 Theatres & a "Drive-In". Forward application to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260, Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses (all departments) for 350-bed General Hospital, gross starting salary $255 per mo., 40-hr. wk. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

General Duty Nurses for all departments. New 250-bed hospital opening early in 1960 in the Niagara Peninsula. 5-day wk. with 3-wk. annual vacation. Residence accommodation available. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

General Duty Nurses (Male & Female) & Certified Nursing Assistants (Immediately) for 88-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Operating Room Nurses (Immediately) for 100-bed General Hospital 25-mi. from Toronto. Good salary, modern residence available. Apply: Director of Nursing, Peel Memorial Hospital, Brampton, Ontario.

General Duty Nurses, Operating Room Nurse (Immediately) for 47-bed hospital, 8-hr. duty, 5½-day wk., annual vacation with pay, statutory holidays, full maintenance in nurses' residence. Apply: Superintendent, General Hospital, Kincardine, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $250 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Nurses for eye, ear, & throat operating room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Staff Nurses for modern well equipped department, gross starting salary $255 per mo., rotating hours of duty. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

Public Health Nurse (qualified) for completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse, (R.N. & P.H.N. degrees) Kent County Board of Health Unit. Apply: W. M. Abraham, Secretary-Treasurer, Kent County Board of Health, 21 Seventh Street, Chatham, Ontario.

Public Health Nurse (Qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,570, starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr. Pension Plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Rd., Etobicoke, Ontario.

Public Health Nurses (Qualified) for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370, annual increment $175, starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Ontario.

Public Health Nurse for generalized public health nursing service; maternal & child health, tuberculosis, school health, etc. Salary $3,500 - $4,500 annually; annual increment $200, hospital plan, P.S.I., pension plan, sick leave — 1½ days per mo., accumulative. 4-wk. vacation yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ont.

Public Health Nurses (2 - Bilingual) for generalized public health nursing service; maternal & child health, tuberculosis, school health, etc. Salary $3,500 - $4,500 annually; annual increment $200, hospital plan, P.S.I. pension plan, sick leave 1½ days per mo., accumulative. 4-wk. vacation yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

QUEBEC

Supervisor of Nurses for Institution of Aged. Challenging opportunity in expanding department for person with initiative, warmth & enthusiasm. Please reply stating age, experience & qualifications, together with names & addresses of 2 references, to: Mrs. S. Angell, Montreal Hebrew Old People's & Sheltering Home, 4373 Esplanade Avenue, Montreal, Quebec.

Nursing Superintendent for modern, accredited 60-bed hospital. Living accommodation available. Apply stating qualifications & salary expected to: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Assistant Head Nurses; Afternoon Supervisor excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses & O.R. Supervisor for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. in effect by February 1960, 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Board & accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurse Immediately: for small General Hospital 40-mi. from North Bay, Ontario. Good salary in effect, 1-mo. annual vacation. Living accommodation in nurses' residence. Pleasant community life with variety of winter & summer recreational activities. Please apply to: Hospital Matron, I. Irwin R.N., Canadian International Paper Company, Temiskaming, Quebec, or to: Mrs. M. Weldon, Industrial Relations Department, Canadian International Paper Company, Sun Life Building, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital in Huntingdon, Quebec, 45-mi. from centre of Montreal with excellent bus service. Gross salary $235 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $250; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., Huntingdon County Hospital, Huntingdon, Que.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

SASKATCHEWAN

Registered Nurses (Female) for accredited 82-bed hospital, salary $255 - $295 per mo., this will be increased by $20 on January 1, 1960. 40-hr. wk., no split shifts. Living accommodation in nurses' residence, laundry of uniforms provided for $8.00-$12 per mo. Transportation refunded after 6-mo. service. Apply: Superintendent of Nurses, Union Hospital, Canora, Saskatchewan.

U.S.A.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses (California) for progressive ultra-modern 200-bed hospital (near Beverly Hills), in medical surgical units & operating room. Starting salary $330 per mo. with 6-mo. increase & yearly increases thereafter; 5-day, 40-hr. wk., 8 paid holidays annually, paid vacation, paid sick leave, free hospitalization & life insurance, plus unemployment & disability insurance. Opportunities for advancement & in-service education program. Work in a friendly efficient atmosphere possessing many new time & effort saving devices. Off-duty time may be spent in the sun & social activities of "Southern California Living". Apply Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses (English Speaking) 500-bed General Hospital in sunny Southern California. $330-$375 base plus $33 shift differential upon registration. **Operation & Delivery Room Nurses** $340-$385 upon registration plus $33 shift differential. Employee health & pension plan. Generous holiday & vacation benefits. Nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 600-bed teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

General Duty Nurses for 100-bed County Hospital, accredited JCAH. San Joaquin Valley, 40-hr. wk., liberal sick leave, 3-wk. annual vacation, 12 annual holidays. Starting salary open, range $314-$392, plus $10 shift differential. Rooms in modern nurses' home at $10 per mo. Write, wire or phone: Superintendent of Nurses, County General Hospital, Tulare, California.

Staff Nurses (all departments) **Head Nurse positions** (several) Come to sunny California, 450-bed Queen of Angels Hospital, excellent working conditions, starting salary $330 for Staff Nurses — $380 for Head Nurses — plus PM & Night premiums — merits increase program, vacations, sick pay etc. Apply: Personnel Director, 2301 Bellevue Avenue, Los Angeles 26, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40 hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

REGIONAL NURSING OFFICER

required for employment by

WORLD HEALTH ORGANIZATION

for

WHO REGIONAL OFFICE, SOUTH EAST ASIA
NEW DELHI, INDIA

Duties include technical responsibility for planning Nursing programs of WHO in designated areas of the Region; advising and assisting National Health Administration with development of their nursing and midwifery services and with programs for training of nurses and midwives.

Apply to: **WHO, PALAIS DES NATIONS, GENEVA, SWITZERLAND, marking envelopes SEARO. Only candidates seriously considered for employment will receive individual replies.**

REGISTERED NURSES

$3,150 - $3,540

(According to Qualifications)

CERTIFIED NURSING ASSISTANTS

$2,040 - $2,400

Sunnybrook Hospital, Toronto, Ont. **Westminster Hospital, London, Ont.**

Deer Lodge Hospital, Winnipeg, Man.

Pension Plan; 3-wk. paid vacation, 3-wk. accumulative sick leave; 5-day wk.; low-cost living in staff residence — for Nurses. Application forms available at Civil Service Commission Offices, National Employment Offices & main Post Offices should be forwarded to the Civil Service Commission Office in the province where the vacancy in which you are interested exists.

ONTARIO: 25 ST. CLAIR AVENUE EAST, TORONTO - MANITOBA: 266 GRAHAM AVENUE, WINNIPEG

NURSING SUPERVISORS

required for

MENTAL HEALTH SERVICES,

ESSONDALE, PROVINCE OF BRITISH COLUMBIA

Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA. IMMEDIATELY. COMPETITION No. 59:152

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies

APPLY TO: DIRECTOR OF NURSING, HALDIMAND WAR MEMORIAL HOSPITAL, DUNNVILLE, ONTARIO

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

GUELPH GENERAL HOSPITAL

REQUIRES

STAFF FOR THE FOLLOWING POSITIONS:

Assistant Head Nurses — General Wards (3), General Staff Nurses, Certified Nursing Assistants, Active Hospital 200-beds, Pleasant city 36,000 — 3 colleges. Excellent salary & personnel policies. Additional salary for postgraduate study in specialty.

For further information apply to:

DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

CITY OF WINNIPEG HEALTH DEPARTMENT

requires

NURSING SUPERVISOR

Minimum requirements for this position are a certificate in Public Health Nursing with at least three years experience. Preference will be given to an applicant with a B.Sc. degree and training in supervision.

This position offers a 5 day week, pension plan, group insurance, holiday and sick pay benefits. Salary range $343-$415 with starting salary dependent upon academic background.

Apply:

CITY OF WINNIPEG,
PERSONNEL DEPARTMENT,
4th FLOOR, 160 PRINCESS ST.,
WINNIPEG 2, MAN.

WOODSTOCK GENERAL HOSPITAL

Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical, Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

PUBLIC HEALTH NURSE (EXPERIENCED)

REQUIRED BY

Ontario Hydro in a Northern Ontario colony to begin February 1960.

General health program includes employee and family care. Practical knowledge of obstetrics and pediatrics is desirable.

Salary conforms to R.N.A.O. schedule with additional benefits.

Write giving full details of education & experience to:

SUPERVISOR, EMPLOYMENT SERVICES,
620 UNIVERSITY AVENUE,
TORONTO, ONTARIO.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3,860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Staff Nurses (all services) for University of Texas Medical Branch, teaching hospital (air conditioned). Good personnel policies. Base salary, rotation: $290 per mo. Evenings or night. $304 per mo. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Porland 1, Oregon.

ONTARIO

General Staff Nurses (4) for convalescent area of 10-beds. Must rotate on all shifts, 8-hr. 5-day wk., good personnel policies, pension policy in effect., 3-wk. annual vacation, 8 statutory holidays. Salary open at present. Apply: Director of Nursing, General Hospital, Stratford, Ontario.

Director of Nursing (with postgraduate training in teaching & administration) for modern 140-bed hospital with school of nursing. Apartment & cafeteria available. Apply stating qualifications & salary expected to: A. G. Middlemiss, Administrator, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

Registered Nurse for 20-bed psychiatric limit. Apply: Director of Nursing, Women's College Hospital, Toronto 5, Ontario.

Registered Nurses for General Duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

General Duty Nurses Excellent salary scales & personnel policies. Apply to: Director of Nurses, Parry Sound General Hospital, Parry Sound, Ontario.

Public Health Nurse (Qualified) Generalized program includes some bedside nursing. Salary $3,200 - $4,250, annual increment $150, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director. Northumberland — Durham Health Unit, Cobourg, Ontario.

BRITISH COLUMBIA

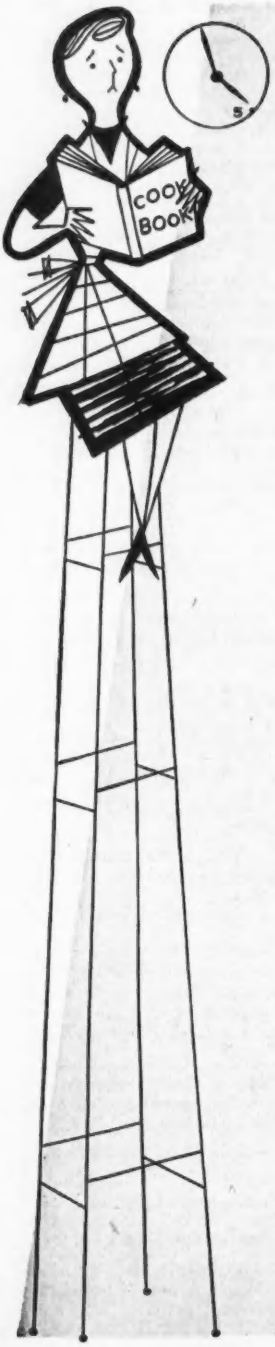
Supervisor (Nursing Service) for 200-bed General Hospital with School of Nursing. Salary range $310-$372 per mo. Starting salary based on experience & preparation. B.C. Registration essential. Apply to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Graduate Nurse (registration not essential) for small Salvation Army Hospital on Vancouver Island. Private living accommodation provided in residence. Salary & policies as recommended by R.N.A.B.C. Apply: Mary Moore Home & Hospital, Box 274, Cobble Hill, British Columbia Phone Cobble Hill 108.

QUEBEC

Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in the Montreal area). Excellent personnel policies, working conditions & accommodation in the Nurses' Home. Reply to: Box 1000, Ste. Agathe des Monts, Quebec.

Public Health Nurse (Bilingual) D.P.H. helpful but not necessary. Responsible position connected with a variety of duties in the Montreal area. Hospital car & travelling expenses supplied. Ideal working conditions. Attractive personnel policies. Apply in writing, giving full particulars, to: Box J, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.



THIS little housewife had a problem — sweet-tooth Hubby on a sweet-free diet. (And beginning to get nervous about it.) She tried everything. Fancy salads. Bigger helpings. But Hubby's frown darkened by the day. Then one day she read in a magazine about a discovery, a new non-caloric sweetener. One that she could actually cook and bake with — in any food, at any temperature. One which gave the perfect taste of sugar — with no bitter aftertaste in ordinary use. That night there were cookies, pudding, coffee — *sweet* coffee — and a big, big smile across the table . . .

Abbott

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